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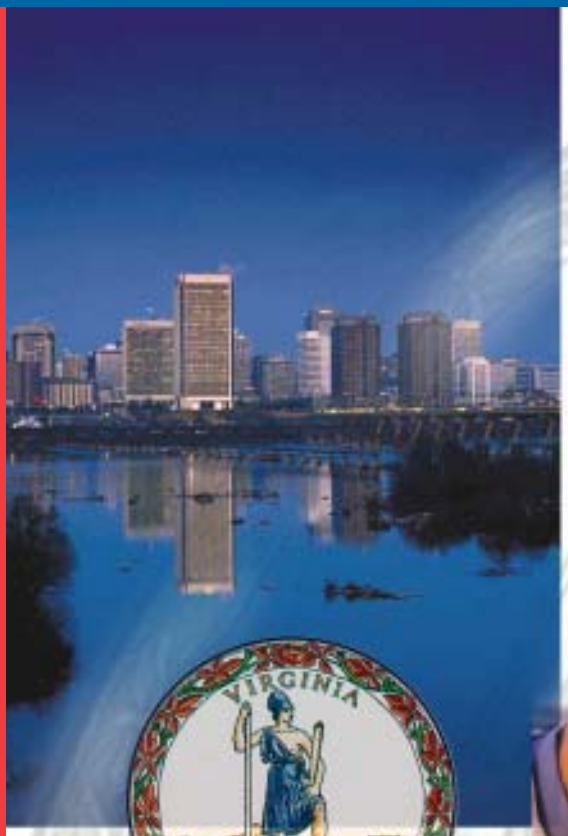

Commonwealth of Virginia Department of Medical Assistance Services

External Quality Review

Anthem BlueCross/BlueShield

CY 2005

We don't provide healthcare... we make it better.

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Anthem Blue Cross/Blue Shield – Operational Systems Review

Introduction and Purpose

The Virginia Department of Medical Assistance Services (DMAS) is charged with the responsibility of evaluating the quality of care provided to recipients enrolled in contracted Medallion II managed care plans. The intent of the Medallion II program is to improve access to care, promote disease prevention, ensure quality care, and reduce Medicaid expenditures. To ensure that the care provided meets acceptable standards for quality, access, and timeliness, DMAS has contracted with the Delmarva Foundation for Medical Care, Inc. (Delmarva) to serve as the External Quality Review Organization (EQRO). This annual report will include the overall results of the Operational Systems Review as well as the findings related to quality, access and timeliness of care.

The Operational Systems Review provides an assessment of the structure, process, and outcomes of the MCO's internal operating systems. The purpose is to identify, validate, quantify, and monitor problem areas in the overall quality assurance program. The review incorporated regulations set forth under the Final Rule of the BBA that became effective on August 13, 2002. The BBA is the comprehensive revision to federal statutes governing all aspects of Medicaid managed care programs as set forth in section 1932 of the Social Security Act and title 42 of the *Code of Federal Regulations* (CFR), part 438 et seq. In support of these regulations and MCO contractual requirements, as part of the calendar year (CY) 2004 review, Delmarva evaluated the following systems:

- Enrollee Rights and Protections (ER) —Subpart C Regulation.
- Quality Assessment and Performance Improvement (QAPI)—Subpart D Regulation.
  - Access Standards.
  - Structure and Operation Standards.
  - Measurement and Improvement Standards.
- Grievance Systems (GS)—Subpart F Regulation.

Following federal requirements for an annual assessment, as set forth in the Balanced Budget Act of 1997 (BBA) and federal EQRO regulations, Delmarva conducted a comprehensive review of Anthem Blue Cross/Blue Shield (Anthem) to assess the plan's performance relative to the quality of care, timeliness of services, and accessibility of services using the results of the Operations Systems Review.

The results of the OSR are contained in this report and are first analyzed by standard (Enrollee Rights, Quality Assessment and Performance Improvement, and Grievance Systems). After this analysis, performance on these standards is assessed relative to quality access and timeliness of services provided to the MCO's members. Strengths and opportunities for improvement are also identified for use in further quality improvement efforts. It is expected that each MCO will utilize the review findings and recommendations found in this report to implement operational systems improvement to become fully compliant with all standards and requirements.

Background on Plan

Anthem consists of three health plans that provide managed care services to Medallion II enrollees in various localities throughout the state of Virginia. These health plans include Anthem HealthKeepers, Inc.; Anthem Peninsula Health Care, Inc.; and Anthem Priority Health Care, Inc. Enrollment in all VA Anthem health plans was 95, 151 members as of December 2005. Localities covered by Anthem are the Tidewater, and Central Virginia, Halifax and Winchester regions. Anthem began providing services to Medallion II enrollees in January 1996 and is an NCQA-accredited health plan with an excellent accreditation status.

Data Sources

Delmarva used many data sources to assess compliance with the operational systems standards. Information was requested from the MCO and reviewed by Delmarva prior to the on-site review. At the time of the on-site review additional data were collected through staff interviews and review of additional documents and systems. Data sources include, but are not limited to:

- Policies and Procedures.
- Interviews with MCO staff.
- Credentialing Files.
- Complaint, Grievance and Appeals Files.
- Committee Meeting Minutes (Quality, Credentialing, and Utilization Management).
- Member Materials.
- Provider Manuals and Materials.
- Internal MCO Staff Training Information.
- Quality Improvement Projects.
- Focused Studies.
- Annual Quality and Utilization Management Program Evaluations.

Methodology

The Anthem Operational Systems Review assessed activities performed by the MCO during the time frame of January 1, 2005 through December 31, 2005 (CY 2005). The purpose was to identify, validate, quantify,

and monitor problem areas in the overall quality improvement program. The review incorporated regulations set forth under the final rule of the BBA that became effective on August 13, 2002. The BBA is the comprehensive revision to federal statutes governing all aspects of Medicaid managed care programs as set forth in Section 1932 of the Social Security Act and Title 42 of the *Code of Federal Regulations* (CFR), part 438 *et seq*. In support of these regulations and health plan contractual requirements, Delmarva evaluated and then assessed compliance for the following systems:

- Enrollee Rights (ER) and Protections—Subpart C Regulation
- Quality Assessment and Performance Improvement (QAPI)—Subpart D Regulation
- Grievance Systems (GS)—Subpart F Regulation

It is expected that each health plan will use the review findings and recommendations for operational systems improvement to become fully compliant with all standards and requirements.

The operational systems standards used in the calendar year (CY) 2005 review were the same as those used in the 2004 review period (January 1, 2004-December 31, 2004) and in the 2003 review period (June- December 2003). These standards incorporate both the BBA and Medallion II contractual requirements. Specifically, these standards include regulations under Subparts C, D, and F of the BBA.

The Operational Systems Review for the period July 2003 through December 2003 was conducted on-site at each MCO. Each element received a compliance rating of "met," "partially met," or "unmet." Each element that was not fully met in the 2003 review was assessed as part of the calendar year (CY) 2004 review.

The CY 2004 review of Operational Systems consisted of a desk review of all documents provided by the MCO to assess compliance with all elements that were partially met or unmet in the 2003 review. This approach required Delmarva staff to conduct an evaluation of changes to policies, procedures, staff, and processes made by the MCO since the last review. The Delmarva team assessed all documentation provided by the MCO to assess whether or not the MCO' had the administrative and operational systems in place and had implemented key operational policies and procedures to meet statutory requirements. During the process, the reviewers requested and the MCOs were asked to provide additional documentation or clarification where questions or concerns were identified. The CY 2005 review included a review of all operational systems standards as in prior reviews and was conducted on-site at the MCO as in the 2003 review.

Consistent with all prior reviews, Delmarva staff completed the review using all information provided by the MCO which included, but is not limited to policies, procedures, interviews, review of complaint, grievance appeals, and credentialing files. Each element within a standard was rated as "met," "partially met," or "unmet". Elements were then rolled up to create a determination of "met", "partially met", or "unmet" for

each of the standards related to enrollee rights and protections, quality assessment and performance improvement, and grievance system. Table 1 describes this scoring methodology.

Table 1. Rating Scale for Operational Systems Review

Rating	Rating Methodology
Met	All elements within the standard were met
Partially Met	At least half the required elements within the standard were met or partially met
Unmet	Less than half the required elements within the standard were met or partially met

The final element rating was determined as follows. All elements that were met in the 2003 review remained met for the CY 2004 review. All elements that were not fully met (partially met or unmet) were reviewed again and the CY 2004 review determination was applied. In CY 2005, all standards were reviewed as in the 2003 review. This provides the DMAS with a current evaluation of the processes that have been developed, implemented, and/or remain in place since the 2003 evaluation.

The results of the OSR are then applied to the categories of quality, access, and timeliness of services for a final analysis.

Results by System

The overall performance rating for each of the three major standards is found in Table 2.

Table 2. Operational Systems Review Results by Standard – Calendar Year 2005 Results

Performance Standard	Overall Performance Rating
Subpart C- Enrollee Rights and Protections	Met
Subpart D- Quality Assessment and Performance Improvement	Partially Met
Subpart F- Grievance Systems	Partially Met

A total of 47 standards are evaluated as part of the Operational Systems Review. All seven (7) Enrollee Rights and 28 of 29 Quality Improvement and Performance Improvement Systems standards were fully met with only one standard partially met. Of the 11 Grievance Systems standards, 10 were fully met and only one was partially met. None of the standards or elements received a review determination of unmet.

Results for each of the 47 Operational Systems Review elements contained within each of the three standards are presented in Table 3.

Table3. 2005 Operational Systems Review Results for Anthem.

Standard Number	Standard Description	Element Ratings Met/Partially Met/Unmet	Standard Rating
ER 1	Written policies regarding enrollee rights and protections.	11/0/0	Met
ER 2	Information provided to enrollees upon enrollment and according to expected time frames.	14/0/0	Met
ER 3	Information and language requirements.	8/0/0	Met
ER 4	Protected health information.	3/0/0	Met
ER 5	Emergency and post-stabilization services.	5/0/0	Met
ER 6	Advanced directives.	5/0/0	Met
ER 7	Rehabilitation Act, ADA.	3/0/0	Met
QA 1	Availability of services: network of appropriate providers.	2/0/0	Met
QA 2	Availability of services: direct access to women's health specialist.	1/0/0	Met
QA 3	Availability of services: second opinion.	1/0/0	Met
QA 4	Availability of services: out of network.	1/0/0	Met
QA 5	Cultural considerations.	1/0/0	Met
QA 6	Coordination and continuity of care.	1/0/0	Met
QA 7	Coordination and continuity of care: additional services for enrollees with special health care needs.	1/0/0	Met
QA 8	Direct access to specialists.	3/0/0	Met
QA 9	Referrals and treatment plans.	0/1/0	Partially Met
QA 10	Primary care and coordination program.	3/0/0	Met
QA 11	Coverage and authorization of services: processing of requests.	9/0/0	Met
QA 12	Coverage and authorization of services-: notice of adverse action.	1/0/0	Met
QA 13	Time frame for decisions: standard authorization decisions.	1/0/0	Met
QA 14	Time frame for decisions: expedited authorization decisions.	2/0/0	Met
QA 15	Provider selection: credentialing and recredentialing requirements.	3/0/0	Met
QA 16	Provider selection: non-discrimination.	1/0/0	Met
QA 17	Provider discrimination prohibited.	1/0/0	Met
QA 18	Provider selection: excluded providers.	1/0/0	Met

Standard Number	Standard Description	Element Ratings Met/Partially Met/Unmet	Standard Rating
QA 19	Provider enrollment and disenrollment: requested by MCO.	1/0/0	Met
QA 20	Provider enrollment and disenrollment: requested by the enrollee.	2/0/0	Met
QA 21	Grievance systems.	4/0/0	Met
QA 22	Subcontractual relationships and delegation.	4/0/0	Met
QA 23	Practice guidelines.	4/0/0	Met
QA 24	Dissemination of practice guidelines.	1/0/0	Met
QA 25	Application of practice guidelines.	1/0/0	Met
QA 26	Quality assessment and performance improvement program.	3/0/0	Met
QA 27	Under/over utilization of services.	1/0/0	Met
QA 28	Care furnished to enrollees with special health needs.	1/0/0	Met
QA 29	Health/management information systems.	5/0/0	Met
GS 1	Grievance system.	8/0/0	Met
GS 2	Filing requirements: procedures.	2/0/0	Met
GS 3	Notice of action.	1/0/0	Met
GS 4	Content of notice action.	5/1/0	Partially Met
GS 5	Record-keeping and reporting requirements.	1/0/0	Met
GS 6	Handling of grievances and appeals: special requirements for appeals.	6/0/0	Met
GS 7	Resolution and notification: grievances and appeals—standard resolution.	2/0/0	Met
GS 8	Resolution and notification: grievances and appeals—expedited appeals.	4/0/0	Met
GS 9	Resolution and notification.	3/0/0	Met
GS 10	Requirements for state fair hearings.	3/0/0	Met
GS 11	Effectuation of reversed appeal resolutions.	2/0/0	Met

Scoring for the individual elements can be found in Appendix I-A1, including recommendations for elements that did not achieve full compliance. Detailed findings for each of the 47 standards, by element are found in Appendix I-A2.

Results by Outcome

Quality, Access and Timeliness

This portion of the annual report provides an evaluation by Delmarva, as the EQRO to assess the progress that Medallion II managed care plans have made in fulfilling the goals of DMAS related to quality, timeliness, and access. This annual report is a mandated activity in the Medallion II contract and the BBA External Quality Review regulations.

For purposes of assessment, Delmarva has adopted the following definitions:

- **Quality,** stated in the federal regulations as it pertains to external quality review, is "the degree to which a Managed Care Organization (MCO) or Prepaid Inpatient Health Plan (PIHP) increases the likelihood of desired health outcomes of its recipients through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge" ("Final Rule: External Quality Review," 2003).

- **Access** (or accessibility), as defined by the National Committee for Quality Assurance (NCQA), is the "timeliness in which an organization's member can obtain available services. The organization must be able to ensure accessibility of routine and regular care and urgent and after-hours care" ("Standards and Guidelines," 2003).

- **Timeliness,** as it relates to utilization management decisions, is defined by NCQA as when "the organization makes utilization decisions in a timely manner to accommodate the clinical urgency of the situation. The intent is that organizations make utilization decisions in a timely manner to minimize any disruption in the provision of health care" ("Standards and Guidelines," 2003). An additional definition of timeliness given in the National Health Care Quality Report "refers to obtaining needed care and minimizing unnecessary delays in getting that care" ("Envisioning the National Health Care," 2001).

Although Delmarva's task is to assess how well Anthem performs in the areas of quality, access, and timeliness from the operational systems review perspective, it is important to note the interdependence of quality, access, and timeliness. Therefore, a measure or attribute identified in one of the categories of quality, access, or timeliness also may be noted under either of the two other areas.

Quality, access, and timeliness of care are expectations for all persons enrolled in the Medallion II managed care program. Ascertaining whether health plans have met the intent of the BBA and state requirements is a major goal of this report. An analysis by quality, access, and timeliness follows.

Quality

Ensuring quality of care for Medicaid managed care recipients is a key objective of the Medallion II program. Various indicators exist that serve as direct and proximate measures of the quality of care and services provided to Medallion II recipients. Along with access and timeliness, these indicators are essential

components of a quality-driven system of care, which is vital for the success of the Medallion II program. Data obtained from clinical studies performed by Delmarva as well as through other avenues of data support the delivery of quality health care to the Medallion II population.

The Quality Assessment and Improvement program appears to be functioning well with 28 of the 29 Quality Assessment and Performance Improvement standards being met. This is an improvement over the last review where 26 of the 29 standards were fully met. Only one of the Enrollee Rights Standards was not fully met in 2004. It was recommended that Anthem should focus its efforts on developing and implementing a policy stating how enrollees will be informed about the availability of a no-cost second opinion. This was addressed in 2005 and is now fully met in this review.

The Member Handbook and Evidence of Coverage contains language informing members that written materials are available in an alternative format for those with visual and hearing impairments and translated or explained for those with limited English or reading proficiency. There are policies and procedures in place to ensure that members are made aware of the availability of interpreter and translation services free-of-charge to members. The Cultural Needs and Preferences Report identified that the MCO did not meet its goal of 80% of members not having difficulty in finding practitioners who meet their cultural, linguistic, and/or ethnic needs. This report includes actions the MCO plans to take to address these issues.

Procedures are in place to afford members the opportunity to have freedom of choice among network providers, receive a second medical opinion at no cost to the enrollee, and members with special needs can request a specialist as their PCP. Female members have direct access to women's health specialists within MCO network for routine and preventative care services, including obstetrical and gynecological services without a referral.

Comprehensive policies and procedures are in place to ensure coordination of care for members with special needs, including those with behavioral health concerns. Behavioral health coordination is assessed in the report entitled Continuity and Coordination between Medical Care and Behavioral Health Care Analysis for 2004-2005. The Care Management Policy discusses how a care management plan is developed. An individualized plan of care for the member is developed involving the member or authorized representative, PCP, specialists, or other treating providers after the member agrees to care management. While the elements of the case management plan are appropriate, there is no overall monitoring standard or requirement that would ensure that all steps of creating a case management plan are occurring "in a timely manner" as required by the element. It is recommended that this be included in the next revision of the Care Management Policy.

Anthem has a comprehensive set of policies and procedures for its health plans that address confidentiality and privacy of member information requirements as required by HIPAA. Procedures are in place for Anthem to provide an individual's PHI available to DMAS within 30 days of request as required by contract.

Anthem has a comprehensive provider credentialing and recredentialing process in place. Delegation procedures are in place and require a pre-assessment of any potential delegate and routine performance monitoring of all delegates. There are sanctioning processes in place for providers with substandard performance. A review of provider credentialing and recredentialing files and delegated agreements provided documentation that this process is in place and functioning well.

Complaint, grievance and appeals policies and procedures are in place. Anthem prohibits individuals from providing incentives for denying, limiting, and/or discontinuing medical services. Consistent with this process, the MCO provides written notice of adverse decisions. The notifications to the members and providers include all the required components including the member right to a State Fair Hearing.

Clinical practice guidelines including preventive and disease specific guidelines are in place, are distributed to providers and are available to members if requested. Guidelines are approved by the Quality Improvement Committee. Per the Anthem Clinical Practice Guideline Development and Monitoring Policy, Clinical guidelines are used as the basis of the disease management programs. Annually the MCO measures performance against four non-preventive clinical practice guidelines, two of which relate to behavioral health. The measurements utilized for each guideline relate to the clinical process of care.

The Staff Inter-Rater Reliability and Physician Inter-Rater Reliability policies and procedures describe how Anthem ensures, by its assessment requirements, consistent application of utilization review criteria by physician and non-physician utilization staff. Pre-authorization processes include an expedited process to ensure members receive authorizations on a timely basis in those cases where a delay in receiving authorization could negatively impact the health of their members.

Access

Access is an essential component of a quality-driven system of care, and historically has been a challenge for Medicaid recipients enrolled in fee-for-service programs. The intent of the Medallion II program is to improve access to care. One of DMAS's major goals in securing approval of the 1915(b) Medicaid waiver application was to develop managed care delivery systems that would remove existing barriers for Medicaid recipients, thereby improving their overall health status, increasing their quality of life, and reducing costly health expenditures related to a fragmented system of care. The findings with regard to access as assessed through the Enrollee Rights, Quality Assessment and Performance Improvement, and Grievance Systems standards are described below.

The Anthem member Handbook and Evidence of Coverage provides members with information about all services available to them and how to access these services. Anthem has performed successfully in this review regarding services for enrollees with special health care needs. Anthem makes a good faith effort to conduct an assessment of enrollees with complex, serious, and/or disabling conditions as identified and reported by the state, within 90 days receipt of notification of Social Security Insurance (SSI) children. An additional area of strength for Anthem is the primary care and coordination program. Anthem coordinates services furnished to enrollees with those of other MCOs to prevent duplication.

Anthem has the appropriate access standards in place and these are distributed through the Provider Manual and newsletters. The Availability Report provides an analysis of access data compared to Anthem's standards and is completed annually. The Managed Care Accessibility Analysis addresses member access to network hospitals and other member services.

As noted in the Quality section, Anthem affords members the opportunity to have freedom of choice among network providers, receive a second medical opinion at no cost to the enrollee, and request of a specialist as their PCP by members with special needs. Female members have direct access to women's health specialists within MCO network for routine and preventative care services, including obstetrical and gynecological services without a referral. There are also procedures in place to ensure that members have access to out-of-network services when Anthem is unable to provide needed services within its network.

Anthem has pre-authorization procedures in place within a functioning process. Timeliness of completion of pre-authorization activities is monitored through the appropriate channels. There are expedited procedures in place to ensure that enrollees receive timely decisions in cases where extenuating circumstances exist. Individuals with the appropriate credentials make the authorization decisions. There are no incentives for persons making the determinations to deny, reduce or limit services. Turn-around timeframes outlined in policies are in accordance with contractual requirements and allow extensions when requested by enrollees.

Overall, access is an area of strength for Anthem and supports the health plan's intent as a quality-driven system of care. Combining all the data sources used to evaluate access, Anthem addressed the areas where the health plan showed vulnerability and corrected identified access issues, furthering the plan in its goal to implement a managed care delivery system that addresses existing barriers for Medicaid recipients.

Timeliness

Access to necessary health care and related services alone is insufficient in advancing the health status of Medallion II recipients. Equally important is the timely delivery of those services, which is an additional goal, established by DMAS for the systems of care that serve Medallion II recipients. The findings related to timeliness are revealed in the sections to follow. Delmarva assessed the Enrollee Rights, Quality Assessment and Performance Improvement, and Grievance System standards to evaluate Anthem's commitment to timeliness of services.

In the last review a recommendation pertaining to the expedited authorization decision timeframe element was made. Anthem was advised to add language to existing written policies and procedures that would describe the extension time frames for expedited authorizations allowed under the state contract. This was completed, and therefore this is met in 2005.

Anthem performed well in the areas of timeliness to include privacy protection and the Health Insurance Portability and Accountability Act (HIPAA), resolution and notification: grievances and appeals, and requirements for state fair hearings. Anthem has an expedited appeal process with a process for extension, and for notifying enrollees of reason for delay. The notices of action include all required information and are provided to members and providers according to required timeframes. Members are informed of their rights to file an external appeal to DMAS within 30 days of the receipt of an adverse determination notice.

Expedited appeals and authorization processes are in place to ensure that members with extenuating circumstances are provided notice as expeditiously as the enrollee's health condition requires and no later than three (3) working days after receipt of the request for service. There are also procedures in place to allow members to request extensions where such an extension would be in their best interest.

Only one Quality Assessment and Performance Improvement standard was not fully met and relates to timeliness. The Care Management Policy discusses the development of a care management plan. An individualized plan of care for the member is developed involving the member or authorized representative, PCP, specialists, or other treating providers, after the member agrees to care management. While the elements of the case management plan are appropriate, there is no overall monitoring standard or requirement that would ensure that all steps of creating a case management plan are occurring "in a timely manner" as required by the element. It is recommended that a methodology for capturing time frames and ensuring compliance with the established time frames be implemented.

Overall Strengths

Quality:

- Twenty-eight (28) of the 29 Quality Assessment and Performance Improvement standards were met.
- The credentialing policies and procedures are in place and functioning well based on a review of provider credentialing and recredentialing files.
- The MCO completed a thorough analysis of issues related to cultural competency. The results identified that the MCO did not meet its goal of 80% of members not having difficulty in finding practitioners who meet their cultural, linguistic, and/or ethnic needs. In response, the MCO has implemented plans to address these identified issues.
- Procedures are in place to afford members the opportunity to have freedom of choice among network providers.
- Members can receive a second medical opinion at no cost to the enrollee.
- Members with special needs can request a specialist as their PCP.
- Female members have direct access to women's health specialists within the MCO network for routine and preventative care services, including obtaining obstetrical and gynecological services without a referral.
- The Continuity and Coordination between Medical Care and Behavioral Health Care Analysis for 2004-2005 provides information for Anthem to use in its quality improvement efforts.
- Anthem has a comprehensive set of policies and procedures for its health plans that address confidentiality and privacy of member information requirements as required by HIPAA and the DMAS contract.
- The appeals process is in place and functioning well as documented through a review of appeal files.
- Qualified individuals are used to make utilization management decisions. Anthem prohibits individuals from being provided incentives for denying, limiting, and/or discontinuing medical services.
- Clinical practice guidelines including preventive and disease specific guidelines are in place, are developed using a sound process, are updated at least every two years and distributed to providers and are available to members if requested.
- Clinical guidelines are used as the basis for the disease management programs. Annually the MCO measures performance against four non-preventive clinical practice guidelines, two of which relate to behavioral health. The measurements utilized for each guideline relate to the clinical process of care.
- Inter-rater reliability procedures are in place to ensure the consistent application of utilization management criteria.

Access:

- The Anthem member Handbook and Evidence of Coverage is comprehensive and provides members with a description of the MCO benefits and services.

- Anthem makes a good faith effort to conduct an assessment of enrollees with complex, serious, and/or disabling conditions as identified and reported by the state, within 90 days receipt of notification of Social Security Insurance (SSI) children. An additional area of strength for Anthem is the primary care and coordination program. Anthem coordinates services furnished to enrollees with those of other MCOs to prevent duplication.
- Anthem has documented the appropriate access standards which are assessed on at least an annual basis. Their findings are documented in a report with recommendations for improvements where deficiencies are identified.
- As noted in the Quality section, Anthem affords members the opportunity to have freedom of choice among network providers, receive a second medical opinion at no cost to the enrollee, and to request a specialist as their PCP.
- Female members have direct access to women's health specialists within the MCO network for routine and preventative care services, including directly obtaining obstetrical and gynecological services without a referral.
- Members have access to out-of-network services when Anthem is unable to provide needed services within its network.
- The pre-authorization procedures are in place with no incentives for staff to deny, reduce or limit services.

Timeliness:

- Anthem has pre-authorization procedures in place and functioning within their processes. The timeliness completion of pre-authorization activities is monitored through the appropriate channels.
- There are expedited authorization procedures in place to ensure that enrollees receive timely decisions in cases where extenuating circumstances exist.
- Turn-around timeframes for authorization of services are outlined in policies, are in accordance with contractual requirements, and allow extensions when requested by enrollees. Timeliness of these decisions is also monitored through the quality improvement channels.
- Anthem performed well in the areas of timeliness to include privacy protection and HIPAA requirements.
- Anthem has an expedited appeal procedure with a process for extension and for notification of enrollees with reasons for any delays. The notices of action include all required information and are provided to members and providers according to required timeframes. Members are informed of their rights to file an external appeal to DMAS within 30 days of the receipt of an adverse determination notice.

Recommendations

This section offers DMAS a set of recommendations to build upon identified strengths and to address the areas of opportunity within the existing programs. These recommendations draw from the findings of those data sources individually and in the aggregate. Delmarva's recommendations for Anthem are as follows:

Only one Quality Assessment and Performance Improvement standard was not fully met and relates to timeliness. The Care Management Policy discusses how a care management plan is developed. After the member agrees to care management, an individualized plan of care is developed involving the member or authorized representative, PCP, specialists, or other treating providers. While the elements of the case management plan are appropriate, there is no overall monitoring standard or requirement to ensure that all steps of creating a case management plan are occurring "in a timely manner" as required by the element. It is recommended that a methodology for capturing time frames and ensuring compliance with the established time frames should be implemented.

The notices of action reviewed by Delmarva did not contain a description of the right to request that benefits continue pending appeal resolution and the circumstances under which the enrollee may be required to pay the costs of services. Several of the files reviewed did indicate that concurrent review decisions could result in the member's being "held harmless' for the charges incurred, and that the treating provider would have to file an appeal to the determination. It is recommended that Anthem put processes in place and revise notices of action documents to ensure that the notices of action contain a description of the right to request that benefits continue pending appeal resolution and the circumstances under which the enrollee may be required to pay the costs of services.

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Appendix IA1
Recommendations At-A-Glance

Performance Rating – Virginia EQRO Performance Standards Subpart C Regulations: Enrollee Rights and Protections					
		Met	Partially Met	Unmet	Recommendations To Meet Element
ER1. The MCO has written policies regarding enrollee rights and protections and ensures that staff and affiliated providers take those rights into account when furnishing services.					
1.1	Enrollee rights and responsibilities.	X			
1.2	Out of area coverage.	X			
1.3	Restrictions on enrollee's freedom of choice among network providers (431.51).	X			
1.4	Referrals to specialty care (422.113c).	X			
1.5	Enrollee notification – termination/change in benefits, services, or service delivery site.	X			
1.6	Procedures that instruct how to contact enrollee services and a description of the department and its functions.	X			
1.7	Procedures for grievances, appeals, and fair hearing procedures (438.10g, 438.400 – 438.424).	X			
1.8	List of non-English speaking languages spoken by which contracted provider.	X			
1.9	Provider-enrollee communications.	X			
1.10	Procedures for sharing information with enrollees – that they are not liable for payment in case of MCO insolvency.	X			
1.11	Enrollment/ Disenrollment.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart C Regulations: Enrollee Rights and Protections					
		Met	**Partially Met**	**Unmet**	**Recommendations To Meet Element**
ER2. Upon enrollment and according to expected timeframes, enrollees are provided a written statement that includes information on the following (see enrollee materials/brochures):					
2.1	Enrollee rights and responsibilities.	X			
2.2	Enrollee identification cards – descriptions, how and when to use cards.	X			
2.3	All Benefits and services included and excluded as a condition of membership, including authorization requirements and any special benefit provisions that may apply to services obtained outside of the system.	X			
2.4	Procedures for obtaining out-of-area coverage.	X			
2.5	Procedures for restrictions on enrollee's freedom of choice among network providers.	X			
2.6	The MCO's policy on referrals for specialty care.	X			
2.7	Procedures for notifying enrollees affected by the termination or change in benefits, services, or service delivery site.	X			
2.8	Procedures on how to contact enrollee services and a description of the functions of enrollee services.	X			
2.9	Procedures for grievances, appeals, and fair hearing procedures, and the amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that enrollees understand the benefits to which they are entitled.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart C Regulations: Enrollee Rights and Protections					
		Met	**Partially Met**	**Unmet**	**Recommendations To Meet Element**
2.10	Names, locations, telephone numbers of, and non-English languages spoken by current contracted providers in the enrollee's service area; include identification of providers that are not accepting new patients. This includes, at a minimum, information on primary care physicians, specialists, and hospitals.	X			
2.11	Procedures for provider-enrollee communications.	X			
2.12	Procedures for providing information on physician incentive plans for those enrollees who request it.	X			
2.13	Procedures to share information with enrollees that they are not liable for payment in the case of MCO insolvency.	X			
2.14	Process for enrollment and disenrollment from MCO.	X			
ER3. Information and Language requirements (438.10).					
3.1	MCO written enrollee information is available in the prevalent, non-English languages (see DMAS contract) of its particular service area.	X			
3.2	Enrollee information is written in prose that is readable and easily understood.	X			
3.3	State requires Flesch-Kincaid readability of 40 or below (at or below 12th grade level).	X			

Performance Rating – Virginia EQRO Performance Standards Subpart C Regulations: Enrollee Rights and Protections					
		Met	**Partially Met**	**Unmet**	**Recommendations To Meet Element**
3.4	Enrollee vital documents must be translated into non-English languages regularly encountered in the eligible population. Examples of vital documents "Applications, consent forms, letters containing important information about participation in programs (such as a cover letter outlining conditions of participation in a Medicaid managed care program),notices advising LEP persons of the availability of free language assistance."	X			
3.5	MCO has provided written material in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency.	X			
3.6	MCO has policies and procedures in place to make interpretation services available and free of charge to the each potential enrollee and enrollee. This applies to all non-English languages, not just those the State identifies as prevalent.	X			
3.7	MCO has policies and procedures in place to notify its enrollees that oral interpretation is available for any language and written information is available in prevalent languages; and how to access those services.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart C Regulations: Enrollee Rights and Protections					
		Met	**Partially Met**	**Unmet**	**Recommendations To Meet Element**
3.8	MCO has policies and procedures in place to inform enrollees and potential enrollees that information is available in alternative formats and how to access those formats.	X			
ER4. 42 C.F.R. 431, Subpart F, and the Code of Virginia, Title 2.1, Chapter 26, (the Privacy Protection Act of 1976) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA).					
4.1	MCO has a confidentiality agreement in place with providers who have access to PHI.	X			
4.2	The Contractor shall implement and maintain appropriate safeguards to prevent the use and disclosure of protected health information (PHI).	X			
4.3	The Contractor shall make an individual's PHI available to the Department within thirty (30) days of an individual's request for such information as notified and in the format requested by the Department.	X			
ER5. Emergency and Post-Stabilization Services (438.114, 422.113c).					
5.1	MCO has policies and procedures in place that define emergency and post-stabilization situations, a description on what to do in an emergency, a telephone number and instructions for obtaining advice on getting care in an emergency, and that prior authorization is not needed.	X			
5.2	MCO has given enrollee information on how to utilize after-hours medical advice and enrollee services department.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart C Regulations: Enrollee Rights and Protections					
		Met	**Partially Met**	**Unmet**	**Recommendations To Meet Element**
5.3	MCO has processes and procedures in place for obtaining emergency services, including use of the 911-telephone system or its local equivalent.	**X**			
5.4	MCO has provided enrollees with a description of how to obtain emergency transportation and other medically necessary transportation. (Medical HelpLine Access).	**X**			
5.5	MCO has provided enrollees with locations of settings that furnish emergency and post-stabilization services covered by MCO.	**X**			
ER6. Advanced Directives.					
6.1	The MCO has provided adult enrollees with written information on advance directives, including a description of the applicable state law.	**X**			
6.2	MCO has requirements to allow enrollees to participate in treatment decisions/options.	**X**			
6.3	Procedures to communicate the risks, benefits, and consequences of treatment or non-treatment.	**X**			
6.4	MCO has policies and procedures to inform enrollees of direct access to women's health specialist within MCO network for routine and preventative care services, as well as a primary care provider.	**X**			

Performance Rating – Virginia EQRO Performance Standards Subpart C Regulations: Enrollee Rights and Protections					
		Met	Partially Met	Unmet	Recommendations To Meet Element
6.5	MCO has policies and procedures to inform enrollees that they may obtain a second opinion from a qualified health care professional within the network or outside the network if necessary, at no cost to enrollee.	X			
ER7. Rehabilitation Act, ADA.					
7.1	MCO is in compliance with Federal and State laws regarding enrollee confidentiality.	X			
7.2	MCO has provided the enrollee with a description of their confidentiality policies.	X			
7.3	MCO has provided enrollee with information on how to obtain a copy of their medical record and how to request records from the MCO.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	**Partially Met**	**Unmet**	**Recommendations To Meet Element**
QA1. 438.206 Availability of services (b).					
1.1	MCO has policies and procedures to maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract as evidenced by the following:	**X**			
1.2	MCO has policies that allow enrollees with disabling conditions, chronic illnesses, or children with special health care needs to request their PCP be a specialist.	**X**			
QA2. 438.206 Availability of services (b)(2).					
2.1	MCO has policies and procedures to inform enrollees of direct access to women's health specialist within MCO network for routine and preventive care services, as well as a primary care provider.	**X**			
QA3. 438.206 Availability of services (b)(3).					
3.1	MCO has policies and procedures to provide for a second opinion from a qualified health care professional within the network, or to provide for the enrollee to obtain one outside the network, at no cost to the enrollee.	**X**			
QA4. 438.206 Availability of services (b)(4).					
4.1	MCO has policies and procedures that provide necessary services out of network, if unable to cover necessary medical services required by enrollee.	**X**			

Performance Rating – Virginia EQRO Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	**Partially Met**	**Unmet**	**Recommendations To Meet Element**
QA5. 438.206(c) (2) Cultural considerations.					
5.1	The MCO has policies and procedures to promote the delivery of services in a culturally competent manner to all enrollees including those with limited English proficiency and diverse cultural and ethnic backgrounds.	X			
QA6. 438.208 Coordination and continuity of care.					
6.1	MCO has policies and procedures in place to ensure coordinated care for all enrollees and provide particular attention to needs of enrollees with complex, serious, and/or disabling conditions.	X			
QA7. 438.208(c) 1-3 Coordination and continuity of care – additional services for enrollees with special health care needs.					
7.1	The MCO makes a good faith effort to conduct an assessment of enrollees with complex, serious, and/or disabling conditions as identified and reported by the state, within 90 days receipt of notification of SSI children.	X			
QA8. 438.208(c) (4) Direct Access to specialists.					
8.1	The MCO has policies and procedures that allow an enrollee with special needs to access a specialist as is appropriate for the condition and identified needs.	X			
8.2	Referral guidelines that demonstrate the conditions under which PCPs make arrangements for referrals to specialty care networks.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Unmet	Recommendations To Meet Element
QA9. 438.208 (d) (2) (ii – iii) Referrals and Treatment Plans.					
9.1	The MCO has a mechanism in place for the development of a treatment plan by the specialist in consultation with the enrollee's PCP, with enrollee participation, and is approved in a timely manner.		X		To receive a determination of met in future reviews, a methodology for capturing time frames and ensuring compliance should be available for review.
QA10. 438.208(e) Primary Care and Coordination Program.					
10.1	MCO coordinates services furnished to enrollee with those of other MCOs, PHPs, or PAHPs to prevent duplication.	X			
10.2	Coordination of care across settings or transitions in care.	X			
10.3	MCO has policies and procedures to protect enrollee privacy while coordinating care.	X			
QA11. 438.210 (b) Coverage and Authorization of Services - Processing of requests.					
11.1	The MCO has policies/procedures in place for processing requests for initial and continuing authorizations of services.	X			
11.2	MCO has policies and procedures in place to ensure that preauthorization requirements do not apply to emergency care, family planning services, preventative services, and basic prenatal care.	X			
11.3	The MCO monitors the application of review criteria for authorizations and takes corrective action to ensure consistent application.	X			
11.4	The MCO has policies and procedures in place for staff to consult with requesting providers when appropriate.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Unmet	Recommendations To Meet Element
11.5	If MCO delegates authorization decisions to subcontractors, the MCO has a mechanism to ensure that standards are met.	X			
11.6	Subcontractor's UM plan is submitted annually and upon revision.	X			
11.7	The MCO has policies and procedures in place that state any decision to deny service authorization requests or to authorize services in an amount, duration, or scope less than requested be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease.	X			
11.8	MCO's service authorization decisions are completed within 2 days of receipt of all necessary information.	X			
11.9	MCO is prohibited from providing incentives for denial, limiting, or discontinuing medical services for enrollees.	X			
QA12. 438.210 (c) Coverage and authorization of services - Notice of adverse action.					
12.1	MCO notifies provider and gives written notice of any decision to deny a service authorization request or to authorize as requested.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Unmet	Recommendations To Meet Element
QA13. 438.210 (d) (1) Timeframe for decisions – Standard Authorization Decisions.					
13.1	MCO provides decision notice as expeditiously as enrollee's health condition requires, not exceeding 14 calendar days following receipt of request for service, with possible extension up to 14 additional calendar days if enrollee requests extension or MCO justifies a need for additional information.	X			
QA14. 438.210 (d) (2) Timeframe for decisions – Expedited Authorization Decisions.					
14.1	The MCO has policies and procedures to make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than three (3) working days after receipt of the request for service.	X			
14.2	The MCO has policies and procedures relating to the extension time frames for expedited authorizations allowed under the state contract.	X			
QA15. 438.214 (b) Provider selection - Credentialing and recredentialing requirements.					
15.1	The MCO has written policies and procedures for selection and retention of providers.	X			
15.2	MCO recredentialing process takes into consideration the performance indicators obtained through QIP, UM program, Grievances and Appeals, and Enrollee satisfaction surveys.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Unmet	Recommendations To Meet Element
15.3	MCO's policies and procedures identify the mechanism for reporting serious quality deficiencies, resulting in suspension or termination of a practitioner, to the appropriate authorities. There is evidence that this process is in place. There is a comprehensive provider appeals process. A review of provider appeals indicates that the process is followed according to policy and procedures.	X			
QA16. 438.214 (c) Provider selection -Nondiscrimination.					
16.1	MCO provider selection policies and procedures do not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.	X			
QA17. 438.12 (a, b) Provider discrimination prohibited.					
17.1	For those individual or group providers who are declined, the MCO provides written notice with reason for decision.	X			
QA18. 438.214 (d) Provider Selection – Excluded Providers.					
18.1	MCO has policies and procedures and adheres to ineligible provider or administrative entities requirements.	X			
QA19. 438.56 (b) Provider Enrollment and Disenrollment – requested by MCO.					
19.1	MCO has policies and procedures that define processes MCO follows when requesting disenrollment, and that the request is in accordance to state contract.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Unmet	Recommendations To Meet Element
QA20. 438.56 (c) Provider Enrollment and Disenrollment – requested by enrollee.					
20.1	MCO has policies and procedures in place for enrollees to request disenrollment.	X			
20.2	MCO has policies and procedures and adheres to timeframes established by state for notifying and transitioning enrollees to new PCPs after PCP disenrollment (30 calendar days for each).	X			
QA21. 438.228 Grievance systems.					
21.1	MCO has a process for tracking requests for covered services that were denied.	X			
21.2	MCO has process for fair hearing notification.	X			
21.3	MCO has process for provider notification.	X			
21.4	MCO has process for enrollee notification and adheres to state timeframes.	X			
QA22. 438.230 Subcontractual relationships and delegation.					
22.1	MCO evaluates prospective subcontractor's ability to perform the activities to be delegated before delegation occurs.	X			
22.2	MCO has a written agreement that specifies the activities and report responsibilities designated to the subcontractor.	X			
22.3	MCO has a process for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	**Partially Met**	**Unmet**	**Recommendations To Meet Element**
22.4	MCO performs an annual review of all subcontractors to evaluate performance and has a mechanism in place to report actions that seriously impact quality of care that may result in suspension/termination of licenses.	X			
QA23. 438.236 (a, b) Practice guidelines.					
23.1	The MCO has adopted practice guidelines that meet current quality standards and the following:				
a)	Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field.	X			
b)	Consider the needs of enrollees.	X			
c)	Are adopted in consultation with contracting health care professionals and	X			
d)	Are reviewed and updated periodically, as appropriate.	X			
QA24. 438.236 (c) Dissemination of Practice Guidelines.					
24.1	The MCO has policies and procedures for the dissemination of guidelines to all affected providers and, upon request, to enrollees and potential enrollees.	X			
QA25. 438.236 (d) Application of Practice Guidelines.					
25.1	MCO decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the established guidelines.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Unmet	Recommendations To Meet Element
QA26. 438.240 Quality assessment and performance improvement program.					
26.1	MCO has an ongoing quality assessment and performance improvement program for the services provided to this population.	X			
26.2	MCO is conducting 1 QIP to achieve, through ongoing measurement and interventions, demonstrable and sustained improvement in significant aspects of clinical and non-clinical care that can be expected to have a favorable effect on health outcomes and enrollee satisfaction.	X			
26.3	The MCO corrects significant systemic problems that come to its attention through internal surveillance, complaints, or other mechanisms.	X			
QA27. 438.240 (b) (2) Basic elements of QAPI program – under/over utilization of services.					
27.1	MCO's QAPI program has mechanisms to detect both underutilization and over utilization of the MCO services.	X			
QA28. 438.240 (b) (3) Basic elements of QAPI program – care furnished to enrollees with special health needs.					
28.1	MCO QAPI program has mechanisms to assess the quality of care and services provided to enrollees with special needs.	X			
QA29. 438.242 Health/Management Information systems.					
29.1	The MCO has information systems capable of furnishing timely, accurate, and complete information about the MCO program.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Unmet	Recommendations To Meet Element
29.2	The MCO information system is capable of: a. accepting and processing enrollment b. Reconciling reports of MCO enrollment/eligibility c. Accepting and Processing provider claims and encounter data d. Tracking provider network composition, access to services, grievances and appeals e. Performing QI activities	X			
29.3	Furnishing DMAS with timely, accurate, and complete clinical and administrative information.	X			
29.4	MCO ensures that data submitted by providers is accurate by: a. Verifying the accuracy and timeliness of reported data b. Screening the data for completeness, logic, and consistency c. Collecting the service information in standard formats for DMAS d. Assigns unique identifiers to providers and requires that identifiers are used when providers submit data to the MCO	X			
29.5	MCO uses encryption processes to send PHI over the internet.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart F Regulations: Grievance Systems					
		Met	Partially Met	Unmet	Recommendations To Meet Element
GS1. 438.402 (a, b) Grievance System.					
1.1	MCO has written policies and procedures that describe the grievance and appeals process and how it operates.	X			
1.2	The definitions for grievances and appeals are consistent with those established by the state 7/03.	X			
1.3	Policies and procedures describe how the MCO intends to receive, track, review, and report all enrollee inquiries, grievances and appeals for the MCO program separately from other programs.	X			
1.4	Policies and procedures describe how MCO responds to grievances and appeals in a timely manner.	X			
1.5	Policies and procedures describe the documentation process and actions taken.	X			
1.6	Policies and procedures describe the aggregation and analysis of the data and use in QI.	X			
1.7	The procedures and any changes to the policies must be submitted to the DMAS annually.	X			
1.8	MCO provides information about grievance and appeals system to all providers and subcontractors.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart F Regulations: Grievance Systems					
		Met	**Partially Met**	**Unmet**	**Recommendations To Meet Element**
GS2. 438.402 (3) Filing Requirements- Procedures.					
2.1	The MCO has grievance and appeal forms and provides written procedures to enrollees who wish to register written grievances or appeals.	X			
2.2	The MCO provides reasonable assistance in completing forms and taking other procedural steps including, but not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.	X			
GS3. 438.404 Notice of Action.					
3.1	Notice of action is written according to language and format requirements set forth in GS 438.10 Information Requirements	X			
GS4. 438.404 (b) Content of Notice Action Content of NOA explains all of the following:					
4.1	The action taken and reasons for the action.	X			
4.2	The enrollee's right to file an appeal with MCO.	X			
4.3	The enrollee's right to request a State fair hearing.	X			
4.4	The procedures for exercising appeal rights.	X			
4.5	The circumstances under which expedited resolution is available and how to request an expedited resolution.	X			
4.6	The circumstances under which the enrollee has the right to request that benefits continue pending appeal resolution and the circumstances under which the enrollee may be required to pay the costs of services.		X		In order to receive a determination of met in future reviews. Anthem must ensure that the notices of action contain a description of the right to request that benefits continue pending appeal resolution and the circumstances under which the enrollee may be required to pay the costs of services.

Performance Rating – Virginia EQRO Performance Standards Subpart F Regulations: Grievance Systems					
		Met	**Partially Met**	**Unmet**	**Recommendations To Meet Element**
GS5. 438.416 Record Keeping and reporting requirements.					
5.1	The MCO maintains a record keeping and tracking system for inquiries, grievances, and appeals that includes a copy of the original grievance or appeal, the decision, and the nature of the decision.	X			
GS6. 438.406 Handling of grievances and appeals – special requirements for appeals.					
6.1	MCO has policies that ensure that individuals who make decisions on grievances and appeals were not involved in previous levels of reviews or decision-making and are health care professionals with appropriate level of expertise in treating the enrollee's condition or disease.	X			
6.2	MCO provides that oral inquires seeking to appeal an action are treated as appeals and confirmed in writing, unless enrollee or provider request expedited resolution.	X			
6.3	MCO provides enrollee with reasonable opportunity to present evidence and allegation of the fact or law in person, as well as in writing.	X			
6.4	MCO informs enrollee of limited time available for cases of expedited resolution.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart F Regulations: Grievance Systems					
		Met	**Partially Met**	**Unmet**	**Recommendations To Meet Element**
6.5	MCO provides enrollee, representative, or legal representation of a deceased enrollee before and during the appeal process, to examine the enrollee case file, including medical records, considered during the appeal process.	**X**			
6.6	MCO continues benefits while appeal or state fair hearing is pending.	**X**			
GS7. 438.408 Resolution and Notification: Grievances and Appeals – Standard Resolution.					
7.1	MCO responds in writing to standard appeals as expeditiously as enrollee's health condition requires- not exceeding 30 days from initial date of receipt of the appeal.	**X**			
7.2	In cases of appeals decisions not being rendered within 30 days, MCO provides written notice to enrollee.	**X**			
GS8. 438.408 Resolution and Notification: Grievances and Appeals – Expedited Appeals.					
8.1	MCO has an expedited appeal process.	**X**			
8.2	The Contractor shall issue decisions for expedited appeals as expeditiously as the enrollee's health condition requires, not exceeding three (3) working days from the initial receipt of the appeal.	**X**			
8.3	MCO has a process for extension, and for notifying enrollee of reason for delay.	**X**			

Performance Rating – Virginia EQRO Performance Standards Subpart F Regulations: Grievance Systems					
		Met	Partially Met	Unmet	Recommendations To Meet Element
8.4	MCO makes reasonable efforts to provide the enrollee with prompt verbal notice of any decisions that are not resolved wholly in favor of the enrollee and shall follow-up within two calendar days with a written notice of action.	X			
GS9. 438.408 (b -d) Resolution and notification.					
9.1	MCO decisions on expedited appeals are in writing and include decision and date of decision.	X			
9.2	For decisions not wholly in favor of enrollee, the MCO provides the enrollee with the right to request a State fair hearing and how to do so, and the right to request to receive benefits while the hearing is pending and how to make the request, explaining that the enrollee may be held liable for the cost of those services if the hearing decision upholds the MCO.	X			
9.3	MCO gives enrollee oral notice of denial and follow up within 2 calendar days with written notice.	X			
GS10. 438.408 (c) Requirements for State Fair Hearings.					
10.1	MCO educates enrollees on state's fair hearing process and that appeal must be in writing within 30 days of enrollee's receipt of notice of any action to deny, delay, terminate, or reduce services authorization request.	X			
10.2	MCO provides state with a summary describing basis for denial and for appeal.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart F Regulations: Grievance Systems					
		Met	**Partially Met**	**Unmet**	**Recommendations To Meet Element**
10.3	MCO faxes appeal summaries to state in expedited appeal cases.	X			
GS11. 438.410 Expedited resolution of appeals, GS. 438.424 Effectuation of reversed appeal resolutions.					
11.1	The MCO must authorize the disputed services promptly and as expeditiously as the enrollee's health condition requires in cases where MCO or the state fair hearing department reverses a decision to deny, limit, or delay services, in cases where those services were not rendered.	X			
11.2	MCO provides reimbursement for those services in accordance with terms of final agreement by state's appeal division.	X			

Appendix IA2 - Detailed Findings

ER1. The MCO has written policies regarding enrollee rights and protections and ensures that staff and affiliated providers take those rights into account when furnishing services.

Element 1.1 – Enrollee rights and responsibilities.
This element is met.

The Anthem Member Rights and Responsibilities Statement Policy contain a detailed description of the member rights and responsibilities. According to the policy, the Member Rights and Responsibilities statement is communicated to members upon enrollment and as revisions occur, through the Evidence of Coverage, the Owner's Manual, member newsletters, and the Anthem website. The Member Rights and Responsibilities statement is communicated to practitioners upon contracting and as revisions occur through practitioner newsletters and the Anthem website.

Element 1.2 – Out-of-area coverage.
This element is met.

The Anthem Member Handbook and Evidence of Coverage specify the circumstances under which members may receive out-of-area coverage. This coverage is limited primarily to emergency services provided to members who sustain an illness or become ill while out of the MCO's service area. The policy is expressed primarily in the Handbook and EOC. The issue is also addressed in the Emergent and Urgent Care Services Policy.

Element 1.3 – Restrictions on enrollee's freedom of choice among network providers (431.51).
This element is met.

The Member Handbook and Evidence of Coverage direct members to call Anthem's Member Services Department to choose their primary care provider (PCP). The publication further states that if members do not call to select a PCP, one will be assigned to them. If members are not happy with the PCP assigned to them, they may request a new one by calling the Member Services Department. Both the local and toll-free telephone numbers for the Member Services Department are provided in the publication.

Element 1.4 – Referrals to specialty care (422.113c).
This element is met.

The Member Handbook and Evidence of Coverage states that members with special conditions are referred to a specialist by their PCPs. The MCO defines special conditions as those that are life threatening, degenerative, or disabling and require specialized care over a prolonged period of time.

Element 1.5 – Enrollee notification – termination/change in benefits, services or service delivery site.
This element is met.

The Member Notification of Benefit Changes Policy addresses how Anthem notifies affected members regarding a change in benefits. The policy indicates that the MCO notifies members of the benefit change via a special mailing and/or an amendment to the appropriate Evidence of Coverage, when possible, 30 calendar days prior to the effective date.

Element 1.6 – Procedures that instruct how to contact enrollee services and a description of department and its functions.
This element is met.

The Member Handbook and Evidence of Coverage states that Anthem's Member Services Department is available to members Monday through Friday from 8:00 a.m. to 6:00 p.m. and can be reached by local and toll-free telephone numbers during those hours. The department also has separate local and toll-free telephone numbers for hearing-impaired members. The Member Services Department may be contacted to answer questions about benefits and ID cards and to provide assistance in changing PCPs.

Element 1.7 – Procedures for grievances, appeals, and fair hearing procedures (438.10g, 438.400 – 438.424).
This element is met.

The Corporate Complaint Policy and the Corporate Appeal Policy describe Anthem's procedures for resolving complaints and appeals. These policies detail the MCO's internal procedures for complaint and appeals handling and also address the external review of adverse decisions by the State of Virginia Department of Medical Assistance Services (DMAS). The procedures are communicated to members in the Member Handbook and Evidence of Coverage.

Element 1.8 – List of non-English languages spoken by which contracted provider
This element is met.

The Member Handbook and Evidence of Coverage indicate that members may identify providers who speak languages other than English by contacting the Member Services Department. This statement is written in English, Cantonese, Korean, Russian, Spanish, and Vietnamese.

Element 1.9 – Provider-enrollee communications.
This element is met.

The Member Rights and Responsibilities Statement Policy states that members have the right to a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.

Element 1.10 – Procedures for sharing information with enrollees – that they are not liable for payment in case of MCO insolvency.
This element is met.

The Member Communication – HMO Insolvency Policy states that language holding members harmless for payment in the case of MCO insolvency is included in the Evidence of Coverage. A review of the Member Handbook and Evidence of Coverage confirmed the presence of this language.

Element 1.11 – Enrollment/Disenrollment.
This element is met.

The New Member Orientation Policy and the Member Termination Policy describe Anthem's enrollment and disenrollment procedures. The enrollment and disenrollment process is also described in the Member Handbook and Evidence of Coverage.

ER2. Upon enrollment and according to expected time frames, enrollees are provided a written statement that includes information on the following (see enrollee materials/brochures):

Element 2.1 – Enrollee rights and responsibilities.
This element is met.

As stated in the Anthem Member Rights and Responsibilities Statement Policy, the Member Rights and Responsibilities statement is communicated to members upon enrollment and as revisions occur through the Evidence of Coverage, the Owner's Manual, member newsletters, and the Anthem website.

Element 2.2 – Enrollee identification cards – descriptions, how and when to use cards.
This element is met.

The Member Handbook and Evidence of Coverage direct members to carry their Anthem ID cards with them at all times and present them whenever they receive services. Members are also given instructions on what to do if their cards are lost or stolen. Identification cards are provided to members upon enrollment.

Element 2.3 – All benefits and services included and excluded as a condition of membership, including authorization requirements and any special benefit provisions that may apply to services obtained outside of the system.
This element is met.

The Member Handbook and Evidence of Coverage contain description of covered services with exclusions and limits placed on them. These are provided to members upon enrollment.

Element 2.4 – Procedures for obtaining out-of-area coverage.
This element is met.

The Member Handbook and Evidence of Coverage specify the circumstances under which members may receive out-of-area coverage. This coverage is limited primarily to emergency services provided to members who sustain an illness or become ill while out of Anthem's service area.

Element 2.5 – Procedures for restrictions on enrollee's freedom of choice among network providers.
This element is met.

The Member Handbook and Evidence of Coverage direct members to call Anthem's Member Services Department to choose their PCP. The publication further states that if members do not call, a PCP will be assigned to them. If members are not happy with the PCP assigned to them, they may request a new one by calling the Member Services Department. Both the local and toll-free telephone numbers for the Member Services Department are provided in the publication.

Element 2.6 – The MCO's policy on referrals for specialty care.
This element is met.

The Member Handbook and Evidence of Coverage states that members with special conditions are referred to a specialist by their PCPs. The MCO defines special conditions as those that are life threatening, degenerative, or disabling and require specialized care over a prolonged period of time.

Element 2.7 – Procedures for notifying enrollees affected by the termination or change in benefits, services, or service delivery site.
This element is met.

The Member Notification of Benefit Changes Policy addresses how Anthem notifies affected members regarding a change in benefits. The policy indicates that the MCO notifies members of the benefit change via a special mailing and/or an amendment to the Evidence of Coverage, when possible, 30 calendar days prior to the effective dates.

Element 2.8 – Procedures on how to contact enrollee services and a description of the functions of enrollee services.
This element is met.

The Member Handbook and Evidence of Coverage state that Anthem's Member Services Department is available to members Monday through Friday from 8:00 a.m. to 6:00 p.m. and can be reached by local and toll-free telephone numbers during these hours. The department also has separate local and toll-free telephone numbers for hearing-impaired members. The Member Services Department may be contacted to answer questions about benefits and ID cards and to provide assistance in changing PCPs.

Element 2.9 – Procedures for grievances, appeals, and fair hearing procedures, and the amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that enrollees understand the benefits to which they are entitled.
This element is met.

Anthem's complaint and appeal procedures and scope of benefits are communicated to members in the Member Handbook and Evidence of Coverage. The Corporate Complaint Policy and the Corporate Appeal Policy describe Anthem's procedures for resolving complaints and appeals. These policies detail the MCO's internal procedures for complaint and appeals handling and also address the external review of adverse decisions by DMAS.

Element 2.10 – Names, locations, telephone numbers of, and non-English languages spoken by current contracted providers in the enrollee's service area, including identification of providers that are not accepting new patients. This includes, at a minimum, information on primary care physicians, specialists, and hospitals.
This element is met.

The Member Handbook and Evidence of Coverage state that members may identify providers that speak languages other than English by contacting the Member Services Department. This statement is written

in English, Cantonese, Korean, Russian, Spanish, and Vietnamese. The MCO indicated that they are currently updating the directory for 2006 to include other languages spoken by physicians.

Element 2.11 – Procedures for provider-enrollee communications.
This element is met.

The Member Rights and Responsibilities Statement Policy includes the right of members to have a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage. The Member Rights and Responsibilities statement is communicated to members upon enrollment and as revisions occur through the Member Handbook and Evidence of Coverage, the Owner's Manual, member newsletters, and the Anthem website.

Element 2.12 – Procedures for providing information on physician incentive plans for those enrollees who request it.
This element is met.

The Member Handbook and Evidence of Coverage direct members to call Anthem's Member Services Department if they would like information regarding provider reimbursement. The local and toll-free telephone numbers for the Member Services Department is provided.

Element 2.13 – Procedures to share information that enrollees are not liable for payment in case of MCO insolvency.
This element is met.

The Member Communication – HMO Insolvency Policy states that language holding members harmless for payment in the case of MCO insolvency is included in the Evidence of Coverage. A review of the Member Handbook and Evidence of Coverage confirmed the presence of this language.

Element 2.14 – Process for enrollment and disenrollment from MCO.
This element is met.

The New Member Orientation Policy and the Member Termination Policy describe Anthem's enrollment and disenrollment procedures. A description of the enrollment and disenrollment process is also described in the Member Handbook and Evidence of Coverage.

ER3. Information and Language requirements (438.10).

Element 3.1 – MCO written enrollee information is available in the prevalent, non-English (see DMAS contract) languages in its particular service area.
This element is met.

Anthem reported that no non-English-speaking group within its membership exceeds the 5% level required by DMAS to publish written member information in that language. The Member Handbook and Evidence of Coverage directs members who need translation services to call the Member Services Department for assistance. The publication provides examples of information translated in five additional languages.

Element 3.2 – Enrollee information is written in prose that is readable and easily understood.
This element is met.

The Member Handbook and Evidence of Coverage, Provider Directory, and sample member newsletters provided evidence that member materials are readable and easily understood.

Element 3.3 – State requires Flesch-Kincaid readability of 40 or below (at or below 12th grade level).
This element is met.

According to its contract with DMAS, Anthem member materials, such as the Member Handbook, must be comprehensive and written to achieve a Flesch total readability score of 40 or better (at or below a 12th grade educational level). The MCO provided examples of various member letters and materials that have been submitted to DMAS for review and approval for compliance with readability requirements.

Element 3.4 – Enrollee vital documents must be translated into non-English languages regularly encountered in the eligible population. Examples of vital documents are "Applications, consent forms, letters containing important information about participation in programs (such as a cover letter outlining conditions of participation in a Medicaid managed care program), [and] . . . notices advising LEP persons of the availability of free language assistance."
This element is met.

The Member Handbook and Evidence of Coverage include language directing members to call Anthem's Member Services Department if they need assistance translating any member materials into a language other than English. The publication provides examples of information translated into Cantonese, Korean, Russian, Spanish, and Vietnamese.

Element 3.5 – MCO has provided written material in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency.
This element is met.

The Written Materials in Alternative Formats Policy evidences Anthem's commitment to informing members of the availability of written member materials in alternative formats. The Member Handbook and Evidence of Coverage contains language informing members that written materials are available in an alternative format for those with visual and hearing impairments and translated or explained for those with limited English or reading proficiency. Members are instructed to contact the MCO's Member Services Department to access any materials in alternative formats and are provided with a local and toll-free number to call.

Element 3.6 – MCO has policies and procedures in place to make interpretation services available and free of charge to the each enrollee and potential enrollee. This applies to all non-English languages, not just those the State identifies as prevalent.
This element is met.

The Member Handbook and Evidence of Coverage indicate that translation services are available to non-English-speaking members at no cost to them. The On Site Interpreting Services Policy describes Anthem's procedures for accessing and using translation services. The policy indicates that interpreter services may be used for all commonly required languages within the State of Virginia.

Element 3.7 – MCO has policies and procedures in place to notify its enrollees that oral interpretation is available for any language and written information is available in prevalent languages, and how to access those services.
This element is met.

The Member Handbook and Evidence of Coverage indicate that translation services are available to non-English-speaking members at no cost. The publication also includes language directing members to call Anthem's Member Services Department if they need assistance translating any member materials into a language other than English. The toll-free number for the Member Services Department is provided for this purpose.

Element 3.8 – MCO has policies and procedures in place to inform enrollees and potential enrollees that information is available in alternative formats and how to access those formats.
This element is met.

The Member Handbook and Evidence of Coverage contain language informing members that written materials are available in an alternative format for those with visual and hearing impairments. Members are instructed to contact the MCO's Member Services Department to access any materials in alternative formats and are provided with a local and toll-free number to call.

ER4. 42 C.F.R. 431, Subpart F, and the Code of Virginia, Title 2.1, Chapter 26 (the Privacy Protection Act of 1976) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Element 4.1 – MCO has a confidentiality agreement in place with providers who have access to protected health information (PHI).
This element is met.

Confidentiality of protected health information (PHI) is addressed in Anthem's provider contracts. The contracts require PCPs and specialists to preserve the full confidentiality of medical records in accordance with the MCO's Medicaid Contract.

Element 4.2 – The Contractor shall implement and maintain appropriate safeguards to prevent the use and disclosure of PHI.
This element is met.

Anthem's Privacy Policy Manual documents all the MCO's procedures for safeguarding and preventing the use and disclosure of PHI. There are various procedures in place to ensure that PHI is not disclosed inappropriately, including the right of members to limit disclosure of PHI in certain circumstances.

Element 4.3 – The Contractor shall make an individual's PHI available to the Department within thirty (30) days of an individual's request for such information as notified and in the format requested by the Department.
This element is met.

The Member Requests for Medical Records Policy indicates that Anthem will make an individual's PHI available to DMAS within 30 days of request and in the format requested by the Department.

ER5. Emergency and Post-Stabilization Services (438.114, 422.113c).

Element 5.1 – MCO has policies and procedures in place that define emergency and post-stabilization situations, a description on what to do in an emergency, a telephone number and instructions for obtaining advice on getting care in an emergency, and that prior authorization is not needed.
This element is met.

The Emergent and Urgent Care Services Policy indicates that Anthem provides coverage for emergent and urgent health care services where a prudent layperson acting reasonably, based on the medical symptoms observed, determines that emergency medical treatment is necessary. Anthem pays for all emergency services that are medically necessary until the clinical emergency is stabilized and until the patient can be safely discharged or transferred.

The Member Handbook and Evidence of Coverage provides members with a definition of what constitutes an emergency and how to respond in cases of an emergency, including calling their PCPs, calling 911, or the Anthem 24-hour Nurse Advisor Line. A toll-free telephone number is provided for the Nurse Advisor Line.

Element 5.2– MCO has given enrollee information on how to utilize after-hours medical advice and enrollee services department.
This element is met.

The Member Handbook and Evidence of Coverage provides information to members regarding the use of after-hours medical services, including calling their PCPs and the use of the 24-hour Nurse Advisor Line, which is available 24 hours a day, 7 days a week. The MCO maintains a toll-free telephone number for the Nurse Advisor Line that is listed on member's ID cards.

Element 5.3 – MCO has processes and procedures in place for obtaining emergency services, including use of the 911-telephone system or its local equivalent.
This element is met.

The Member Handbook and Evidence of Coverage provides members with a definition of what constitutes an emergency and how to respond in cases of an emergency, including calling their PCPs, calling 911, or the Anthem 24-hour Nurse Advisor Line. A toll free telephone number is provided for the Nurse Advisor Line.

Element 5.4 – MCO has provided enrollees with a description of how to obtain emergency transportation and other medical necessary transportation. (Medical HelpLine Access).
This element is met.

The Member Handbook and Evidence of Coverage Emergency states that medically necessary ambulance transportation is provided by Anthem when prearranged by a PCP and authorized by the MCO. Non-emergency transportation is provided for covered medical care. Members must call the transportation number on their identification card to schedule non-emergency transportation at least five days before their appointment.

Element 5.5 – MCO has provided enrollees with locations of settings that furnish emergency and post-stabilization services covered by MCO.
This element is met.

The Provider Directory, which members receive upon enrollment, identifies the Anthem network hospitals that provide emergency and post-stabilization services.

ER6. Advanced Directives.

Element 6.1 – The MCO has provided adult enrollees with written information on advance directives, including a description of the applicable state law.
This element is met.

The Advance Directives Policy states that Anthem is committed to informing members of their advance directive options and addresses how Anthem communicates this to members. The Member Handbook and Evidence of Coverage provides information to members regarding the Virginia Health Care Decisions Act which addresses living wills and advance directives. The summary informs members they may decide in advance if they desire life-prolonging procedures to be performed, and it indicates that it is a member's right to accept or refuse medical or surgical treatment and to formulate advance directives.

Element 6.2– MCO has requirements to allow enrollees to participate in treatment decisions/options.
This element is met.

The Member Rights and Responsibilities statement published in the Member Handbook and Evidence of Coverage includes the right of members to know about their treatment options and participate in decision making about their health care.

Element 6.3– Procedures to communicate the risks, benefits, and consequences of treatment or non-treatment.
This element is met.

The Member Rights and Responsibilities statement published in the Member Handbook and Evidence of Coverage includes the right of members to know about their treatment options and participate in decision making about their health care. The statement also includes the member right to refuse treatment. The Member Handbook and Evidence of Coverage includes a section on Living Wills and Powers of Attorney, which states that members have a right to decide the health care they seek, the right to accept or reject health care, and the right to plan and direct the types of health care they receive.

Element 6.4 – MCO has policies and procedures to inform enrollees of direct access to women's health specialists within MCO network for routine and preventative care services, as well as a primary care provider.
This element is met.

The Member Handbook and Evidence of Coverage indicate that family planning services can be provided to members by the provider of their choice. The publication also indicates that, with the exception of hospital services and outpatient surgery, services received from an OB/GYN do not require a PCP authorization.

Element 6.5 – MCO has policies and procedures to inform enrollees that they may obtain a second opinion from a qualified health care professional within the network or outside the network if necessary, at no cost to enrollee.
This element is met.

The Member Handbook and Evidence of Coverage states that second opinions are covered at no cost to members for diagnosing an illness and confirming a plan of care. Members must request and receive a referral from their PCP before seeing a provider for a second opinion.

ER7. Rehabilitation Act, ADA.

Element 7.1 – MCO is in compliance with Federal and State laws regarding enrollee confidentiality.
This element is met.

Anthem's Notice of Privacy Practices describes the procedures in place to ensure member privacy and confidentiality. Member confidentiality is also addressed in the Privacy Policy Manual, which also documents the MCO's procedures for safeguarding and preventing the use and disclosure of PHI as required by the Health Insurance Portability and Accountability Act (HIPAA).

Element 7.2 – MCO has provided the enrollee with a description of their confidentiality policies.
This element is met.

Anthem's Notice of Privacy Practices is distributed to members upon enrollment and describes the MCO's confidentiality policies, including the use and disclosure of PHI.

Element 7.3 – MCO has provided enrollee with information on how to obtain a copy of their medical record and how to request records from the MCO.
This element is met.

The Notice of Privacy Practices informs members of their right to access PHI, including their medical records. Members are directed to contact the Member Services Department to obtain a copy of their records.

QA1. 438.206 Availability of services (b).

Element 1.1 – MCO has policies and procedures to maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract as evidenced by the following:

- Network Provider Composition.
- Provider Enrollment into Medicaid.
- Network Provider Licensing and Certification Standards.
- Enrollee to PCP ratios.
- Specialist Services.
- Enrollee to Dentist Ratios.
- Inpatient Hospital Access.
- Policy of Nondiscrimination.
- Twenty-four hour coverage.
- Travel Time and Distance.
- Appointment Standards.
- Emergency Services Coverage – provider contracts.
- Monitoring/Corrective Action.

This element is met.

A number of policies and documents were reviewed to result in a met status for this element.

- The 2005 Availability Report collects and reports access data and compares it to Anthem's standards for access. The information is collected annually and is used to measure practitioner availability against mandated standards. Medicaid Membership Goals include primary care physician (PCP), hospital, and specialty availability and access based on time and distance standards.
- The policy and procedure Anthem Availability Monitoring of Practitioners, Providers and Practice Sites describes how the MCO ensures that the network is composed of an adequate mix and number of practitioners within Anthem's service areas. The policy includes consideration of "racial, cultural, ethnic, and linguistic needs and preferences of its member population." Information used for this analysis is obtained, according to MCO, "by utilizing member satisfaction survey data, member complaint data, and other health and/or ethnic data." Standards used for measurement reflect DMAS regulations, namely, those for availability of PCPs, SCPs, OB/GYN, behavioral health care practitioners, dental teams (an age-limited service), and hospitals based on mile and minute travel measurements. Monitoring data in accordance with this policy may result in recommendations for improvement, and follow-up measurements are reported to the Medical Management Committee. Member satisfaction information and analysis of complaint and other information are also used to assess and modify the practitioner network as needed.

- The Managed Care Accessibility Analysis for Hospitals includes an analysis of member access to network hospitals.
- The Medicaid Primary Care Physician Agreement, in the section entitled Provision of Services and Professional Requirements, states that the "Primary Care Physician shall make necessary and appropriate arrangements to assure the availability of physician services to his/her Member patients on a twenty-four (24) hours per day, seven (7) days per week basis . . . " This contract also addresses non-discrimination requirements, as does the specialist's contract.

Element 1.2 – MCO has policies that allow enrollees with disabling conditions, chronic illnesses, or children with special health care needs to request their PCP be a specialist.
This element is met.

MCO has policies in the Anthem Credentialing and Recredentialing Program Description that describe circumstances under which a member may have a specialist serve as their PCP. They include cases where a member requires significant, ongoing, frequent care outside the realm of a PCP's expertise. The member must have a chronic, unstable medical condition not expected to improve significantly in the short term. The policy specifies, inter alia, that the specialist must provide after-hours backup coverage comparable to that of a PCP.

QA2. 438.206 Availability of Services (b)(2).

Element 2.1 – MCO has policies and procedures to inform enrollees of direct access to women's health specialist within MCO network for routine and preventative care services, as well as a primary care provider.
This element is met.

Per the Access to Care Policy under the Women's Health Issues section, "all services, except inpatient hospital services and outpatient surgery, received from an obstetrician-gynecologist . . . do not require the authorization of the PCP."
The Member Handbook and Evidence of Coverage Book contain the same language: "all services, except inpatient hospital services and outpatient surgery, received from an obstetrician-gynecologist . . . do not require the authorization of the PCP.

QA3. 438.206 Availability of Services (b)(3).

Element 3.1 – MCO has policies and procedures to provide for a second opinion from a qualified health care professional within the network, or to provide for the enrollee to obtain one outside the network, at no cost to the enrollee.
This element is met.

The Access to Care Policy in the Evidence of Coverage section, entitled Second Opinions notes that members can obtain a second opinion from a qualified health care professional within the network or outside the network at no cost to the enrollee. Members may receive a referral for a second opinion from a provider following a consultation with the Primary Care physician.

QA4. 438.206 Availability of Services (b)(4).

Element 4.1 – MCO has policies and procedures that provide necessary services out of network, if unable to cover necessary medical services required by enrollee.
This element is met.

The Out of Network Authorizations for Specialty Care Policy discusses the use of non-network providers for special circumstances when services are not available in the network. Such circumstances include access issues and emergencies.

The Continuation of Care Policy explains how continued care may be approved if the member is a patient in active treatment. Members may request and receive continued health care services for:

- Up to 90 days from the date of their PCP's notice of termination.
- Second and third trimester care.
- Terminal care.
- Chronic or acute condition (active treatment).
- Other circumstances, for example, "a patient in active treatment with a mental health or substance abuse provider may receive authorized transition visits until another provider can be secured."

QA5. 438.206(c)(2) Cultural Considerations.

Element 5.1 – The MCO has policies and procedures to promote the delivery of services in a culturally competent manner to all enrollees including those with limited English proficiency and diverse cultural and ethnic backgrounds.
This element is met.

The Availability Monitoring of Practitioners, Provider, and Practice Sites Policy states that Anthem considers the racial, cultural, ethnic, and linguistic needs and preferences of its member population when assessing its practitioner network strategy. The MCO utilizes member satisfaction survey data, member complaint data, and other health and/or ethnic data to assist in this effort.

Anthem compiled a 2005 Cultural Needs and Preferences Report, which collected and analyzed data to determine if the MCO's practitioner network is meeting members' cultural, ethnic, racial, and linguistic needs. The report concluded that the MCO did not meet its internal goal of 80% of members not having difficulty in finding practitioners who meet their cultural/linguistic/ethnic needs.

Anthem proposed actions that would to taken to address this deficiency, including:

- Educating all members about the availability of practitioner gender/language information on the on-line provider directory.
- Encouraging the submission of race/ethnicity and spoken language information from practitioners to Anthem for more accurate analysis of the demographic characteristics of the network.
- Encouraging racial/cultural diversity training for network practitioners.

The Written Materials in Alternative Formats Policy indicates that Anthem is committed to informing members of the availability of written member materials in alternative formats. The Member Handbook and Evidence of Coverage contain language informing members that written materials are available in an alternative format for those with visual and hearing impairments. The Member Handbook and Evidence of Coverage also contain language that translation services are available to non-English-speaking members at no cost to them. The On Site Interpreting Services Policy describes Anthem's procedures for accessing and using translation services, which indicate that interpreter services may be used for all commonly required languages within the State of Virginia.

QA6. 438.208 Coordination and Continuity of Care.

Element 6.1 – MCO has policies and procedures in place to ensure coordinated care for all enrollees and provide particular attention to needs of enrollees with complex, serious, and/or disabling conditions. **This element is met.**

The Care Management Policy discusses coordination of care and how case managers identify at-risk individuals and monitor progress toward goals and the effectiveness of the plan of care. If changes or problems occur, the case manager assesses the issue and facilitates resolution.

The Anthem Continuity and Coordination of Care Monitoring Policy and Procedure describe how care is coordinated for all enrollees, with focus on the needs of enrollees with complex, serious, and/or disabling

conditions. Monitoring occurs annually for medical care and biennially for coordination between somatic and behavioral care.

QA7. 438.208(c) 1-3 Coordination and Continuity of Care – Additional Services for Enrollees with Special Health Care Needs.

Element 7.1 – The MCO makes a good faith effort to conduct an assessment of enrollees with complex, serious, and/or disabling conditions as identified and reported by the state, within 90 days receipt of notification of SSI children.
This element is met.

Advanced Care Management Desktop Procedure Children with Special Health Care Needs describes how the Children with Special Health Care Needs are provided a risk assessment children meeting the requirement for SSI eligibility requirements) within 90 days of plan enrollment. They are then entered into case management as appropriate.

QA8. 438.208(c)(4) Direct Access to Specialists.

Element 8.1 – The MCO has policies and procedures that allow an enrollee with special needs to access a specialist as is appropriate for the condition and identified needs.
This element is met.

The policy and procedure Access to Care requires that if a patient has an ongoing special condition, he or she may receive a referral to a specialist for that condition following consultation with the PCP. The specialist will be responsible for providing and coordinating the individual's primary and specialty care related to the initial specialty referral. If a specialist would most appropriately coordinate the member's care, the MCO will recognize that need and issue a standing referral to that specialist.

Element 8.2 – Referral guidelines that demonstrate the conditions under which PCPs make arrangements for referrals to specialty care networks.
This element is met.

The policy and procedure Access to Care contains a description of the conditions under which a PCP may refer as member to a specialist for care.

Element 8.3 – The MCO has a mechanism in place for the development of a treatment plan by the specialist in consultation with the enrollee's PCP, with enrollee participation, and is approved in a timely manner.
This element is met.

The policy and procedure Care Management requires that the case manager will develop an individualized plan of care for the member. The development of the plan of care will be a collaborative effort between the member or the member's authorized representative and the PCP, with input from any pertinent specialists or treating providers involved in the patient's care. The member and his or her PCP must be in agreement and acceptance to participate in case management.

QA9. 438.208 (d) (2) (ii–iii) Referrals and Treatment Plans.

Element 9.1 – The MCO has a mechanism in place for the development of a treatment plan by the specialist in consultation with the enrollee's PCP, with enrollee participation, and is approved in a timely manner.
This element is partially met.

The Care Management Policy discusses how a care management plan is developed. An individualized plan of care for the member is developed involving the member or authorized representative, PCP, specialists, or other treating providers after the member agrees to care management. While the elements of the case management plan are appropriate, there is no overall monitoring standard or requirement that would ensure that all steps of creating a case management plan are occurring "in a timely manner" as required by the element.

To receive a determination of met in future reviews, a methodology for capturing time frames and ensuring compliance should be available for review.

QA10. 438.208(e) Primary Care and Coordination Program.

Element 10.1 – MCO coordinates services furnished to enrollee with those of other MCOs, PIHP, PAHP to prevent duplication.
This element is met.

The Care Management Policy describes how services are coordinated by working with the member's PCP, specialists, and other health care professionals, to minimize risks of duplication.

The Transition of Care Policy discusses transition of care from non-network providers and actions that are taken to ensure continuity and avoid gaps and duplication of care.

Element 10.2 – Coordination of care across settings or transitions in care (NCQA QI-9). Continuity and coordination between medical and behavioral health care for co-existing conditions.
This element is met.

The Care Management Policy describes how services are coordinated for Behavioral Health High Risk Care Management. Care managers are involved with coordinating, monitoring, and tracking patients discharged from the hospital and patients at significant risk of hospitalization. Care coordination between specialists and PCPs is facilitated as noted in the Care Plan Development section.

The MCO tracks continuity between mental and somatic health care providers as found in the report Continuity and Coordination between Medical Care and Behavioral Health Care 2004–2005. Measures, results, analysis, and conclusions are found in the report. Anthem has been providing incentives for behavioral health providers to communicate with somatic health specialists. This program has been ongoing for a number of years. The MCO's QA Pay for Performance Program related to sharing information has improved these outcomes. There is evidence of an increased rate of patients with chronic illnesses being referred to mental health providers.

The Anthem Continuity and Coordination of Care Monitoring Policy and Procedure describes how monitoring occurs to determine that care is coordinated for enrollees with somatic and behavioral care issues.

Element 10.3 – MCO has policies and procedures to protect enrollee privacy while coordinating care.
This element is met.

The Wellpoint, Inc. Privacy Policy Manual Version 5.0 2004 provides specific information concerning the issue of enrollee privacy for staff, including case managers. Confidentiality, transfer of protected health information (PHI), and other HIPAA issues are clearly delineated in this policy.

QA11. 438.210 (b) Coverage and Authorization of Services – Processing of Requests.

Element 11.1 – The MCO has policies/procedures in place for processing requests for initial and continuing authorizations of services.
This element is met.

The Anthem Blue Cross and Blue Shield Utilization Management Program Description 2005 sets forth the requirements and procedures for the authorization of initial and continued requests for service.

Element 11.2 – MCO has policy and procedure in place to ensure that preauthorization requirements do not apply to emergency care, family planning services, preventative services and basic prenatal care.
This element is met.

The policy and procedure Access to Care waives the prior authorization requirement for OB/GYN care for women, family planning services, and emergency services.

Element 11.3 – The MCO monitors the application of review criteria for authorizations and takes corrective action to ensure consistent application.
This element is met.

The policies and procedures Staff inter-Rater Reliability and Physician Inter-Rater Reliability describe how Anthem ensures, by its assessment requirements, consistent application of utilization review criteria by physician and non-physician utilization staff.

Element 11.4 – The MCO has policy and procedure in place for staff to consult with requesting providers when appropriate.
This element is met.

The policies and procedures Review Process – Medical Necessity and/or Experimental/Investigative require that, when possible, utilization staff will consult with the requesting physician prior to rendering an adverse decision based on medical necessity.

Element 11.5 – If MCO delegates authorization decisions to subcontractors, the MCO has a mechanism to ensure that standards are met.
This element is met.

The policy and procedure Anthem Delegated Activities and the Anthem Blue Cross and Blue Shield Utilization Management Program Description 2005 details the requirements of all entities that are delegated UM decisions.

Element 11.6 – Subcontractor's UM plan is submitted annually and upon revision.
This element is met.

The policy and procedure Anthem Delegated Activities includes a requirement for the submission of the delegate's UM program annually as well as upon revision.

Element 11.7 – The MCO has policy and procedure in place that state any decision to deny service authorization requests or to authorize services in an amount, duration, or scope less that requested be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease.
This element is met.

The Anthem Blue Cross and Blue Shield Utilization Management Program Description 2005 requires that all utilization determinations be made by the appropriate medical professionals.

Element 11.8 – MCO's service authorization decisions are completed within 2 days of receipt of all necessary information.
This element is met.

The policy and procedure Medical Review Decision Making & Timeliness of Decisions requires that all utilization determinations be made within two working days of the receipt of the proper information.

Element 11.9 – MCO is prohibited from providing incentives for denial, limiting, or discontinuing medical services for enrollees.
This element is met.

The policy and procedure Associate, Consultant, or Agent Compensation—Utilization Review Conduct prohibits the use of incentives to influence utilization determinations.

QA12. 438.210 (c) Coverage and authorization of services – Notice of Adverse Action.

Element 12.1 – MCO notifies provider and gives written notice of any decision to deny a service authorization request or to authorize as requested.
This element is met.

The policies and procedures Review Process – Medical Necessity and/or Experimental/Investigative, and the Anthem Blue Cross and Blue Shield Utilization Management Program Description 2005 require that a letter be mailed to the enrollee and provider for each adverse determination.

QA13. 438.210 (d) (1) Timeframe for decisions – Standard Authorization Decisions.

Element 13.1 – MCO provides decision notice as expeditiously as enrollee's health condition requires, not to exceed 14 calendar days following receipt of request for service, with possible extension up to 14 additional calendar days if enrollee request extension or MCO justifies a need for additional information.
This element is met.

The policy and procedure Medical Review Decision Making & Timeliness of Decisions Policy includes the turn-around time frames for all types of standard authorizations. None of the timeframes exceeds the 14 day requirement.

QA14. 438.210 (d) (2) Timeframe for Decisions – Expedited Authorization Decisions.

Element 14.1 – The MCO has policy and procedure to make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than three (3) working days after receipt of the request for service.
This element is met.

The policy and procedure Medical Review Decision Making & Timeliness of Decisions requires that verbal notification of urgent (expedited) authorization determinations must be made within 24 hours of receipt. The policy requires that written notice be made within 72 hours of the verbal notice of the review determination.

Element 14.2 – The MCO has policy and procedure relating to the extension time frames for expedited authorizations allowed under the state contract.
This element is met.

The policy and procedure Medical Review Decision Making & Timeliness of Decisions permits the extension of time for a utilization determination up to 14 days if the extension is shown to be in the interest of the member.

QA15. 438.214 (b) Provider selection – Credentialing and Recredentialing Requirements.

Element 15.1 – The MCO has written policies and procedures for selection and retention of providers using 2003 NCQA guidelines.
This element is met.

The Anthem Credentialing and Recredentialing Program Description details Anthem's credentialing and recredentialing criteria and processes.

Element 15.2 – MCO recredentialing process takes into consideration the performance indicators obtained through QIP, UM program, Grievances and Appeals, and Enrollee satisfaction surveys.
This element is met.

Per the Anthem Credentialing and Recredentialing Program Description, Anthem reviews and considers any member complaints in determining ongoing credentialing status. Quality of care issues are identified if medical care rendered to members of Anthem is substandard or places the enrollee at risk. Per the policy, "Practitioners must allow Anthem to conduct on-site office reviews including assessment of medical record completeness, utilization, quality of care, safety and sanitation, and compliance with nationally accepted lab and x-ray practice standards in determining the practitioner's ongoing credentials."

Element 15.3 – MCO's policies and procedures identify the mechanism for reporting serious quality deficiencies, resulting in suspension or termination of a practitioner, to the appropriate authorities. There is evidence that this process is in place. There is a comprehensive provider appeals process. A review of provider appeals indicates that the process is followed according to policy and procedures.
This element is met.

The Anthem Credentialing and Recredentialing Program Description in its section, Anthem Quality of Care Termination and Practitioner Appeal Policy and Procedures, details the procedure used for terminating a practitioner's participation for a quality of care issue (i.e., where the care provided is determined to be substandard and/or detrimental to the health and well-being of the members.) The MCO notifies the provider of its action/ recommendation, and the appeal process is explained to the provider. The time frames for providing feedback to the provider and the appeal time frames are clearly delineated in the policy. A written notice advises the provider of the nature of the proposed action and review rights. The chairperson of the Hearing Review Committee, as applicable, reports any action to the National Practitioner Data Bank (NPDB) and the Health Integrity and Protection Data Bank as appropriate.

QA16. 438.214 (c) Provider Selection – Nondiscrimination.

Element 16.1 – MCO provider selection policies and procedures do not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.
This element is met.

Per the Anthem Credentialing and Recredentialing Program Description credentialing and recredentialing decisions are not based on an applicant's race, ethnic/national identity, gender, age, sexual orientation, or the types of procedures or types of patients in which the practitioner specializes.

QA17. 438.12 (a, b) Provider Discrimination Prohibited.

Element 17.1 – For those individual or group providers who are declined, the MCO provides written notice with reason for decision.
This element is met.

The Anthem Credentialing and Recredentialing Program Description states, "Practitioners have the right to review the information obtained by Anthem in support of their application with the exception of information that is peer review protected." Practitioners can correct erroneous information. Per the policy, "practitioners denied or terminated due to a credentialing or recredentialing issue will be sent a letter notifying the practitioner/provider of the decision. The letter will be sent to the practitioner/provider via certified mail and will be effective as of the date stated in the letter."

QA18. 438.214 (d) Provider Selection – Excluded Providers.

Element 18.1 – MCO has policies and procedures and adheres to ineligible provider or administrative entities requirements set forth in K. Provider Relations.
This element is met.

The Anthem Credentialing and Recredentialing Program Description explains that when a network provider fails to meet any one of the MCO's credentialing or recredentialing criteria, his/her participation status is reviewed for possible termination. The applicable eligibility criteria are clearly delineated in the document.

QA19. 438.56 (b) Provider Enrollment and Disenrollment – Requested by MCO.

Element 19.1 – MCO has policies and procedures that define processes MCO follows when requesting disenrollment, and that the request is in accordance to state contract.
This element is met.

The MCO is prohibited from disenrolling a member per DMAS requirements. Requests for a member disenrollment are referred to DMAS. These processes for member disenrollment are outlined in the Member Handbook and Evidence of Coverage.

QA20. 438.56 (c) Provider Enrollment and Disenrollment – Requested by Enrollee.

Element 20.1 – MCO has policies and procedures in place for enrollees to request disenrollment.
This element is met.

The Member Handbook and Evidence of Coverage provides information regarding what procedures members should use to disenroll. Per its contract with DMAS, Anthem may not disenroll members and this is clearly noted in the Member Handbook and Evidence of Coverage.

Element 20.2 – MCO has policies and procedures and adheres to timeframes established by state for notifying and transitioning enrollees to new PCPs after PCP disenrollment (30 calendar days for each).
This element is met.
The Member Notification of Practitioner Termination Policy and Procedure discusses how the MCO notifies "affected members via letter of the PCP's termination, when possible, 90 calendar days prior to the effective termination date." The MCO also transfers the members to a new PCP based on location, and issues a new ID card with the new PCP's name 15 days prior to the effective termination date.

QA21. 438.228 Grievance Systems.

Element 21.1 – MCO has a process for tracking requests for covered services that were denied.
This element is met.

The policy and procedure Medical Review Decision Making & Timeliness of Decisions requires that all utilization determinations be made logged into the utilization management tracking log and responded to within two working days of the receipt of the proper information.

Element 21.2 – MCO has process for fair hearing notification.
This element is met.

The Member Handbook and the policies and procedures Anthem Member Appeal and Anthem Member Complaint contain the provision that members may file an external appeal to DMAS within 30 days of the receipt of an adverse determination notice.

Element 21.3 – MCO has process for provider notification.
This element is met.

The policy and procedure Medical Review Decision Making & Timeliness of Decisions requires that practitioners and members of medical management issue determinations in a timely manner as required

by the exigencies of the situation. Written notification of determinations shall be sent to the member, PCP or attending physician, and other providers that may be impacted by the decision.

Element 21.4 – MCO has process for enrollee notification and adheres to state timeframes.
This element is met.

The policy and procedure Medical Review Decision Making & Timeliness of Decisions requires that practitioners and members of medical management issue determinations in a timely manner as required by the exigencies of the situation. Written notification of determinations shall be sent to the member, PCP or attending physician, and other providers that may be impacted by the decision.

QA22. 438.230 Subcontractual Relationships and Delegation.

Element 22.1 – MCO evaluates prospective subcontractor's ability to perform the activities to be delegated before delegation occurs.
This element is met.

Anthem Delegated Activities Policy and Procedure describes oversight of delegated activities as a component of the Quality Improvement Program (QIP). The policy explains how Anthem determines which organizations are appropriate for delegation of quality improvement, utilization management, credentialing, and members' rights and responsibilities. Their activities must be consistent with Anthem standards, NCQA standards, URAC standards, and any applicable State or Federal laws for the specific function.

Delegation determination is based on the following:

- Establishing the delegate's ability to provide the scope of delegation requested, only granting delegation if the delegate demonstrates competency/compliance with the delegation requirements for quality improvement, utilization management, credentialing, or members' rights and responsibilities.
- A delegation agreement between Anthem and the delegate.
- A predelegation evaluation, including document review, before a contract is signed, and an annual evaluation of the delegate's performance. Based on this evaluation, the delegation will continue, be terminated, or modified.
- A review by the appropriate QI committee of the delegation evaluation and that committee's recommendation regarding the delegation.

Element 22.2 – MCO has a written agreement that specifies the activities and report responsibilities designated to the subcontractor.
This element is met.

A sample Delegated Credentialing / Recredentialing Agreement contract and the Delegated Activities Agreement were reviewed. They specifically delineate the reports and documents that the delegate must provide to meet contract requirements. Information must be consistent with NCQA Standards and any requirements of the State of Virginia.

Element 22.3 – MCO has a process for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.
This element is met.

The Delegated Activities Agreement discusses termination of the agreement without cause at any time (upon prior written notice) and states that the MCO may terminate this agreement immediately upon determination that the delegate fails to perform its duties and obligations specified under the agreement. Corrective action plans may be requested if the contract is to continue.

Element 22.4 – MCO performs an annual review of all subcontractors to evaluate performance and has a mechanism in place to report actions that seriously impact quality of care that may result in suspension/termination of licenses.
This element is met.

The 2004 QI Program evaluation was reviewed. It provides evidence of annual delegated activity audits without major issues being identified during these audits. All delegation agreements were continued into the next year.

QA23. 438.236 (a, b) Practice Guidelines.

Element 23.1 – The MCO has adopted practice guidelines that meet current NCQA standards and the following:
This element is met.

Per the Anthem Clinical Practice Guideline Development and Monitoring Policy, Clinical guidelines are used as the basis of the disease management programs. Annually the MCO measures performance against "four non-preventive clinical practice guidelines, two of which relate to behavioral health. The measurements utilized for each guideline relate to the clinical process of care."

Guidelines and updates (approved by the Quality Improvement Committee) are distributed to participating practitioners in a number of ways, including the practitioner newsletters, the Anthem website, and special mailings. The MCO communicates the guidelines' availability on the Anthem

website, and provides this information through the welcome letters to new practitioner. Paper copies of all guidelines are available upon request.

a) Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field.
This component is met.

The guidelines are based on clinical evidence and may be from nationally recognized sources. The MCO reviews and updates clinical practice guidelines (CPGs) at least every two years or based on new scientific evidence that may impact the validity of the existing guideline or on national CPG changes.

b) Consider the needs of the enrollees.
This component is met.

Anthem Clinical Practice Guideline Development and Monitoring Policy and Procedure discusses how the program adopts CPGs relevant to its membership, in areas such as preventive health screening, acute and chronic medical care, and behavioral health. The Member Handbook and Evidence of Coverage describe how the member may contact Member Services for assistance in obtaining a copy of the CPGs.

c) Are adopted in consultation with contracting health care professionals, and
This component is met.

Minutes of the 2005 Managed Care Advisory Panel, which is composed of a number of MCO-contracted health care professionals, were reviewed. There is evidence of review and endorsement of guidelines prior to the guidelines being finalized by the QI council.

d) Are reviewed and updated periodically, as appropriate.
This component is met.

The guidelines are based on clinical evidence and may be from nationally recognized sources. The Quality Improvement Committee approves all guidelines. The MCO reviews and updates CPGs at least every two years or based on new scientific evidence that may impact the validity of the guideline or on national clinical practice guideline changes.

QA24. 438.236 (c) Dissemination of Practice Guidelines.

Element 24.1 – The MCO has policies and procedures for the dissemination of guidelines to all affected providers and, upon request, to enrollees and potential enrollees.
This element is met.

Per the Anthem Clinical Practice Guideline Development and Monitoring Policy and Procedure, Clinical guidelines and updates (approved by the Quality Improvement Committee) are distributed to participating practitioners in a number of ways, including the practitioner newsletters, the Anthem website, and special mailings. The MCO communicates the guidelines' availability on the Anthem website, and provides this information through welcome letters to new practitioners. Paper copies of all guidelines are available upon request.

Per the Anthem Clinical Practice Guideline Development and Monitoring Policy and Procedure the MCO annually distributes preventive health screening guidelines and updates to members through member newsletters, the Anthem website; and special mailings.

QA25. 438.236 (d) Application of Practice Guidelines.

Element 25.1 – MCO decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the established guidelines.
This element is met.

The Criteria: Application, Review, Evaluation, and Disclosure Policy describes how the MCO applies clinical review criteria, "adapted for its utilization management and case management operations and business needs, to determine whether health services are medically necessary . . . utilization management decisions are made in a consistent manner and in the best interest of the member."

Anthem periodically reviews and evaluate commercial and internally developed criteria to ensure that criteria are consistent with accepted medical practice standards and are supported by reasonable medical evidence. Participating providers are provided an opportunity to review and comment on clinical review criteria. Per the policy, there is a process for "development or revision of criteria incorporating thorough research of national medical organization guidelines, medical literature, and local physician input."

QA26. 438.240 Quality Assessment and Performance Improvement Program.

Element 26.1 – MCO has an ongoing quality assessment and performance improvement program for the services provided to this population.
This element is met.

Anthem Health Plans of Virginia, Inc. Quality Improvement Program 2005 describes the MCO's QA and performance improvement program. The scope of the program includes the following, demonstrating quality assessment and appropriate actions taken if issues are identified.

Quality of Care and Service.

- Services provided across the continuum of care.
- Services provided by individual practitioners.
- Acute, chronic, and behavioral health care services.
- High-volume, high-risk services.
- Continuity and coordination of care monitoring.
- Patient safety monitoring.
- Monitoring of compliance with clinical practice guidelines.
- Monitoring of the utilization of preventive health services.
- Monitoring of the utilization of behavioral health services.

Health Management.

- Disease Management programs.
- Preventive behavioral health programs.
- Health promotion activities linked to quality improvement activities.
- Education of practitioners and members.

Element 26.2 – MCO is conducting 1 QIP to achieve, through ongoing measurement and interventions, demonstrable and sustained improvement in significant aspects of clinical and non-clinical care that can be expected to have a favorable effect on health outcomes and enrollee satisfaction.
This element is met.

Based on the review of the Quality Improvement Activity (QIA): Improving the Use of Appropriate Medications for People with Asthma, there is evidence of ongoing measurement and interventions, and improvement in a significant aspect of clinical care that is expected to have a favorable effect on health outcomes and enrollee satisfaction.

Element 26.3 – The MCO corrects significant systemic problems that come to its attention through internal surveillance, complaints, or other mechanisms.
This element is met.

The Anthem Quality Improvement Indicator Monitoring Policy and Procedure is a component of the Quality Improvement Program of Anthem Health Plans of Virginia. The policy describes how the plan monitors information concerning the quality of care and service delivered to members to identify areas where customer expectations or performance standards are not being met and action should be taken. Quality of care and service indicators relevant to the plan population is created and is provided for oversight. This includes service standards, internally established performance goals, and industry benchmarks. Actions are taken as needed.

Another example of oversight is seen in the Anthem Over/Under Utilization Monitoring Policy and Procedure (undated) which describes how the MCO monitors for over and under utilization of services. HEDIS/ CAHPS information is also analyzed to detect systemic problems with access to health care.

Anthem Member Complaint Policy and Procedure describes how the plan identifies, resolves, and tracks member complaints about the health plan and practitioners/providers and/or their staff. The plan monitors complaints about practitioners, reviewing a practitioners' history of complaints every six months. Complaint history is reviewed to determine if further action is necessary. The plan also aggregates complaint types and analyzes sources of member dissatisfaction annually.

QA27. 438.240 (b) (2) Basic elements of QAPI program – under/over utilization of services.

Element 27.1 – MCO's QAPI program has mechanisms to detect both underutilization and overutilization of the Medallion II services.
This element is met.

Anthem Over/Under Utilization Monitoring Policy and Procedure (undated) describes how the MCO monitors for potential problems with the over and under utilization of services. The MCO reviews and acts upon information from HEDIS data collection and utilization data, including:

- Inpatient discharges/1,000.
- Outpatient visits/1,000.
- Mental health average inpatient length of stay.
- HEDIS®/CAHPS™ 3.0H Survey Results on selected questions:
  - Question #9 – How much of a problem was it to get a referral to a specialist you needed to see?
  - Question #24 – How much of a problem was it to get the care you or a doctor believed was necessary?

- Question #26 – How much of a problem were delays in your health care while you waited for approval from your health plan?

The MCO creates thresholds based on national and regional benchmarks to aid in identifying over or under utilization issues. Action is taken by the Medical Management Committee, based on the results, including interventions and reassessment.

QA28. 438.240 (b) (3) Basic Elements of QAPI Program – Care Furnished to Enrollees with Special Health Needs.

Element 28.1 – MCO QAPI program has mechanisms to assess the quality of care and services provided to enrollees with special needs.
This element is met.

Per the Advanced Care Management Desktop Procedure Children with Special Health Care Needs, Quality of Care and Service assessments for CSHCN include:

- Case management/plan development involving the CSHCN, families, providers, and other community resources to ensure quality of care.
- Service quality, to measure satisfaction with the care provided for the CSHCN.
- Appropriate provider networks and specialist access.
- Care coordination to ensure coordination of care for the CSHCN "with other health care professionals/disciplines and community resources."

For other vulnerable populations, the Care Management Policy discusses how a care management plan is developed involving the member/authorized representative, PCP, specialists, or other treating providers after the member agrees to work with care management.

QA29. 438.242 Health/Management Information systems.

Element 29.1 – The MCO has information systems capable of furnishing timely, accurate, and complete information about the Medallion II program.
This element is met.

Application Disaster Recovery Plan – TriMed Application Profile, as one example, discusses the TriMed System, an in-house-developed medical management system for referrals, admission reviews, outpatient reviews, case management, and appeals. The MCO began using the system in April 1999 and has continued to update it. This system provides information that supports the quality and utilization programs involved in day-to-day operations and is part of the system that provides data/ information for the QI program for Medicaid members.

Element 29.2 – The MCO information system is capable of:

a) Accepting and processing enrollment reports.
b) Reconciling reports with MCO enrollment/eligibility files.
c) Accepting and processing provider claims and encounter data.
d) Tracking provider network composition, access to services, grievances and appeals.
e) Performing QI activities.

This element is met.

A number of policies have been reviewed whose content demonstrates the capacity of the MCO to collect the data listed above:

- Medicaid Enrollment Process.
- Utilization Management Data and System Security Process.
- Evidence of the ability of the MCO to collect the data elements necessary for medical management includes the capacities of the TriMed System, Application Disaster Recovery Plan - TriMed Application Profile.
- Review of a 2005 Medicaid Appeal Log with categories, decisions, and dates of actions taken.
- The Anthem Member Complaint Policy and Procedure in Attachment B – External Complaint Reporting (to DMAS concerning member complaints.)
- Other activities performed in the areas of processing of UM data, CAHPS collection capabilities, and member access assessment as demonstrated in the 2005 Availability Report, which collects and reports access information and compares it to the MCO's standards for access.

Element 29.3 – Furnishing DMAS with timely, accurate and complete clinical and administrative information.

This element is met.

Medicaid Enrollment Process details how the DMAS data is collected and processed and feedback is given to the State if issues or errors are encountered. The policy discusses generation of exception reports, if data or member discrepancies are noted between the MCO's AMISYS computer program and DMAS.

Anthem Member Complaint Policy and Procedure in Attachment B – External Complaint Reporting discusses how DMAS is provided information concerning member complaints.

The Anthem Professional Provider Billing Guidelines discusses how data from providers is collected to provide information to DMAS.

Element 29.4 – MCO ensures that data submitted by providers is accurate by:

a) Verifying the accuracy and timeliness of reported data.
b) Screening the data for completeness, logic and consistency.
c) Collecting service information in standard formats for DMAS.
d) Assigns unique identifiers to providers and requires that identifiers are used when providers submit data to MCO.

This element is met.

The Anthem Professional Provider Billing Guidelines discusses how claims/ encounter data from providers is accepted and reviewed. Issues including collection of data in standardized formats are delineated in the document. The requirements for timely and accurate filing are also addressed in this document.

Element 29.5 – MCO uses encryption processes to send PHI over the internet.

This element is met.

Per the Wellpoint, Inc. Privacy Policy Manual Version 5.0 2004, e-mail is sent using the WellPoint's ZixIt encrypted e-mail platform or "otherwise encrypted in a manner consistent with the Privacy and Security Office's encryption standards then in effect."

GS1. 438.402 (a, b) Grievance System.

Element 1.1 – MCO has written policies and procedures that describe the grievance and appeals process and how it operates.
This element is met.

The policy and procedure Anthem Member Appeal contains a description of the appeals and grievance procedures. This policy includes a description of the submission and resolution process as well as the resolution periods and responsible parties.

Element 1.2 – The definitions for grievances and appeals are consistent with those established by the state 7/03.
This element is met.

The policies and procedures Anthem Member Appeal and Anthem Member Complaint define appeals and grievances in a manner consistent with the Medallion II MCO contract.

Element 1.3 – Policy and procedure describe how the MCO intends to receive, track, review, and report all enrollee inquiries, grievances and appeals for the Medallion II program separately from the commercial program.
This element is met.

The policies and procedures Anthem Member Appeal and Anthem Member Complaint contain a description of the process for monitoring appeals and grievances. The policies also require reporting of trends that may have been identified through the quality improvement (QI) structure. This monitoring system is stratified by line of business.

Element 1.4 – Policy and procedure describes how MCO responds to grievances and appeals in a timely manner.
This element is met.

The policies and procedures Anthem Member Appeal and Anthem Member Complaint contain a description of the period of resolution. These resolution time frames are consistent with the requirements of the Medallion II contract.

Element 1.5 – Policy and procedure describe the documentation process and actions taken.
This element is met.

The policies and procedures Anthem Member Appeal and Anthem Member Complaint contain a description of the process for filing and resolution of an appeal or grievance, including documentation requirements as well as responsible parties.

Element 1.6 – Policy and procedure describe the aggregation and analysis of the data and use in QI.
This element is met.

The policies and procedures Anthem Member Appeal and Anthem Member Complaint require that all appeals and grievance data be compiled and reviewed for quality improvement activities.
These data are routinely monitored within the quality committeeQI structure.

Element 1.7 – The procedures and any changes to the policy and procedure must be submitted to the DMAS annually.
This element is met.

The policies and procedures Anthem Member Appeal and Anthem Member Complaint require that changes to the policies and procedures be reviewed by DMAS annually.

Element 1.8 – MCO provides information about grievance and appeals system to all providers and subcontractors.
This element is met.

The Anthem provider Provider manual Manual contains a description of the appeals and grievance process for both members and providers. Appeals and grievance requirements are described in the service agreements for all subcontractors.

GS2. 438.402 (3) Filing Requirements – Procedures.

Element 2.1 – The MCO has grievance and appeal forms and provides enrollees with written procedures to enrollees who wish to register written grievances or appeals.
This element is met.

The policies and procedures Anthem Member Appeal and Anthem Member Complaint contain a description of the procedures by which a member may file a written grievance or complaint. The Member Handbook and Evidence of Coverage contain a description of the appeals process and the method and contact information for the submission of a written or verbal appeal.

Element 2.2 – The MCO provides reasonable assistance in completing forms and taking other procedural steps including, but not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.
This element is met.

The Member Handbook and Evidence of Coverage include a listing of languages that are spoken and the process for contacting the language line. Assistance with writing and filing a grievance or appeal is available through the language line and through Customer Service.

GS3. 438.404 Notice of Action.

Element 3.1 – Notice of action is written according to language and format requirements set forth in GS. 438.10 Information Requirements.
This element is met.

The notices of action templates have been reviewed and approved by the State of Virginia Department of Medical Assistance Services (DMAS) as appropriate for use according to the readability requirements of the MCO contract.

GS4. 438.404 (b) Content of Notice of Action.

Content of NOA the notice of action explains all of the following:

Element 4.1 – The action taken and reasons for the action.
This element is met.

Ten notices of action were reviewed, and each contained a description of the action taken and the reason for the action.

Element 4.2 – The enrollee's right to file an appeal with MCO.
This element is met.

Ten notices of action were reviewed and each contained a description of the members' right to appeal the action taken.

Element 4.3 – The enrollee's right to request a State fair hearing.
This element is met.

Ten notices of action were reviewed and each contained a description of the enrollees' right to request a State fair hearing.

Element 4.4 – The procedures for exercising appeal rights.
This element is met.

Ten notices of action were reviewed and each contained a description of the procedures for exercising appeal rights.

Element 4.5 – The circumstances under which expedited resolution is available and how to request an expedited resolution.
This element is met.

Ten notices of action were reviewed and each contained a description of the circumstances under which expedited resolution is available and how to request an expedited resolution.

Element 4.6 – The circumstances under which the enrollee has the right to request that benefits continue pending appeal resolution and the circumstances under which the enrollee may be required to pay the costs of services.
This element is partially met.

Thirty notices of action were reviewed; the notices did not contain a description of the right to request that benefits continue pending appeal resolution and the circumstances under which the enrollee may be required to pay the costs of services.

Several of the files reviewed did indicate that concurrent review decisions could result in the member's being "held harmless' for the charges incurred, and that the treating provider would have to file an appeal to the determination.

The policy and procedure Notification Letters indicates that each letter will contain a statement regarding potential member liability that may be incurred if the member pursues the service despite denial. The Member Handbook and Evidence of Coverage and the policies and procedures Anthem Member Appeal and Anthem Member Complaint contain a statement that the member may continue to receive benefits while an appeal is pending, but may be responsible for the cost of the care if the appeal determination is not in his or her favor of the enrollee.

In order to receive a determination of met in future reviews. Anthem must ensure that the notices of action contain a description of the right to request that benefits continue pending appeal resolution and the circumstances under which the enrollee may be required to pay the costs of services.

GS5. 438.416 Record Keeping and Reporting Requirements.

Element 5.1 – The MCO maintains a record keeping and tracking system for inquiries, grievances, and appeals that includes a copy of the original grievance or appeal, the decision, and the nature of the decision.
This element is met.

The policies and procedures Anthem Member Appeal and Anthem Member Complaint contain a requirement that the content of the grievances and appeals be collected and analyzed for use in quality improvement QI activities. Ten appeals files were reviewed, and each file was found to contain a copy of the original adverse determination, the member's request for appeal, and the appeal determination.

GS6. 438.406 Handling of grievances Grievances and appeals Appeals – special Special requirements Requirements for Appeals.

Element 6.1 – MCO has policies that ensure that individuals who make decisions on grievances and appeals were not involved in previous levels of reviews or decision-making and are health care professionals with appropriate level of expertise in treating enrollee's condition or disease.
This element is met.

The policies and procedures Anthem Member Appeal and Anthem Member Complaint require that all appeal and grievance decisions be made by individuals of the appropriate skill and who were not involved in any previous decisions in the matter at issue.

Element 6.2 – MCO provides that verbal inquiries seeking to appeal an action are treated as appeals and confirmed in writing, unless enrollee or provider request expedited resolution.
This element is met.

The policies and procedures Anthem Member Appeal and Anthem Member Complaint include allow verbal inquiries as a means of initiating an appeal. These Verbal inquiries are put in writing and are the written form mailed to the member for written confirmation of the request for appeal.

Element 6.3 – MCO provides enrollee with reasonable opportunity to present evidence and allegations of the fact or law in person, as well as in writing.
This element is met.

The policies and procedures Anthem Member Appeal and Anthem Member Complaint require that the member or representative be provided an opportunity to submit comments, documents, and other information pertinent to the pre-service or post-service appeal. This information can be presented verbally or in writing, and in person at the option of the member. Medical information and/or other information pertinent to review of the pre-service or post-service appeal may be obtained via telephone, facsimile machine, e-mail communication, etc.or other means.

Element 6.4 – MCO informs enrollee of limited time available for cases of expedited resolution.
This element is met.

The Member Handbook and Evidence of Coverage and the policies and procedures Anthem Member Appeal and Anthem Member Complaint contain a description of the periods for expedited resolution and the conditions under which those time frames may be extended.

Element 6.5 – MCO provides enrollee, representative, or legal representation of a deceased enrollee before and during the appeal process, to examine the enrollee case file, including medical records, considered during the appeal process.
This element is met.

The Member Handbook and Evidence of Coverage and the policies and procedures Anthem Member Appeal and Anthem Member Complaint require that the appeal record be available for examination at any time during the process of the appeal.

Element 6.6 – MCO continues benefits while appeal or state fair hearing is pending.
This element is met.

The Member Handbook and Evidence of Coverage and the policies and procedures Anthem Member Appeal and Anthem Member Complaint require that benefits may be continued during the appeal process. The policies also indicate that the member may be responsible for the cost of the care delivered in the event of an adverse appeal decision.

GS7. 438.408 Resolution and Notification: Grievances and Appeals – Standard Resolution.

Element 7.1 – MCO responds in writing to standard appeals as expeditiously as enrollee's health condition requires-—not exceeding 30 days from initial date of receipt of the appeal.
This element is met.

The Member Handbook and Evidence of Coverage and the policies and procedures Anthem Member Appeal and Anthem Member Complaint require that appeals be responded to within 30 days of the initial receipt of the appeal. All of the ten reviewed appeals files showed resolution Ten appeals files were reviewed, all were resolved within 30 days of receipt of the appeal.

Element 7.2 – In cases of appeals decisions not being rendered within 30 days, MCO provides written notice to enrollee.
This element is met.

The Member Handbook and Evidence of Coverage and the policies and procedures Anthem Member Appeal and Anthem Member Complaint require that written notice to the member of a delay of in the resolution of an appeal.

GS8. 438.408 Resolution and Notification: Grievances and Appeals – Expedited Appeals.

Element 8.1 – MCO has an expedited appeal process.
This element is met.

The Member Handbook and Evidence of Coverage and the policy and procedure Anthem Member Appeal contain a description of the expedited appeal process.

Element 8.2 – The Contractor shall issue decisions for expedited appeals as expeditiously as the enrollee's health condition requires, not exceeding three working days from the initial receipt of the appeal.
This element is met.

The Member Handbook and Evidence of Coverage and the policy and procedure Anthem Member Appeal require that expedited appeals be resolved within three working days of the initial receipt.

Element 8.3 – MCO has a process for extension, and for notifying enrollee of reason for delay.
This element is met.

The Member Handbook and Evidence of Coverage and the policy and procedure Anthem Member Appeal contain a description of the requirements for an extension of the expedited appeals time frames, whether requested by the member and or by the MCO.

Element 8.4 – MCO makes reasonable efforts to provide the enrollee with prompt verbal notice of any decisions that are not resolved wholly in favor of the enrollee and shall follow- up within two calendar days with a written notice of action.
This element is met.

The Member Handbook and Evidence of Coverage and the policies and procedures Anthem Member Appeal and Anthem Member Complaint require that the MCO provide prompt verbal notice of any adverse determination, followed within 24 hours by written notice of the decision.

GS9. 438.408 (b-d) Resolution and Notification.

Element 9.1 – MCO decisions to expedite appeals are in writing and include decision and date of decision.
This element is met.

The policy and procedure Anthem Member Appeal requires that the final determination of an expedited appeal must be made in writing within 24 hours of the verbal notification.

Element 9.2 – For decisions not wholly in favor of enrollee, the MCO provides the enrollee with the right to request a State fair hearing and how to do so, and the right to request to receive benefits while the hearing is pending and how to make the request, explaining that the enrollee may be held liable for the cost of those services if the hearing decision upholds the MCO.
This element is met.

The Member Handbook and Evidence of Coverage and the policies and procedures Anthem Member Appeal and Anthem Member Complaint contain a statement that the member may continue to receive benefits while an appeal is pending, but may be responsible for the cost of the care if the appeal determination is not in the member's favor of the enrollee.

Element 9.3 – MCO gives enrollee verbal notice of denial and follows up within 2 two calendar days with written notice.
This element is met.

The Member Handbook and Evidence of Coverage and the policies and procedures Anthem Member Appeal and Anthem Member Complaint require that written notice of an adverse determination be followed within 24 hours of the verbal notice.

GS10. 438.408 (c) Requirements for State Fair Hearings.

Element 10.1 – MCO educates enrollees on state's fair hearing process and that appeal must be in writing within 30 days of enrollee's receipt of notice of any action to deny, delay, terminate, or reduce services authorization request.
This element is met.

The Member Handbook and Evidence of Coverage and the policies and procedures Anthem Member Appeal and Anthem Member Complaint contain a provision that members may file an external appeal to DMAS within 30 days of the receipt of an adverse determination notice.

Element 10.2 – MCO provides state with a summary describing basis for denial and for appeal.
This element is met.

The policies and procedures Anthem Member Appeal and Anthem Member Complaint require that the MCO submit to the State a summary of each determination for which a fair hearing has been requested.

Element 10.3 – MCO faxes appeal summaries to state in expedited appeal cases.
This element is met.

The Member Handbook and Evidence of Coverage and the policy and procedure Anthem Member Appeal requires that a summary of an expedited appeal be faxed to DMAS for expedited review.

GS11. 438.410 Expedited Resolution of Appeals, GS. 438.424 Effectuation of Reversed Appeal Resolutions.

Element 11.1 – The MCO must authorize the disputed services promptly and as expeditiously as the enrollee's health condition requires in cases where MCO or SFHD reverses a decision to deny, limit, or delay services, in cases where those services were not rendered.
This element is met.

The policy and procedure Anthem Member Appeal requires that an adjustment be made to any claims involved following an appeal decision. It is recommended that the policy be updated to reflect the

process steps to be taken in the event of an appeal decision that results in overturning the initial determination.

Element 11.2– MCO provides reimbursement for those services in accordance with terms of final agreement by state's appeal division.
This element is met.

The policy and procedure Anthem Member Appeal requires that the MCO must pay within 30 days claims associated with a denial reversed on appeal to the State Commissioner.?

Summary of Documents Reviewed		
Element	**Document**	**Date**
ER 1 & ER 2	Member Rights and Responsibilities Statement Policy	03/2005
	Anthem Member Handbook and Evidence of Coverage	07/2005
	Provider Directory	2005
	Member Notification of Benefit Changes Policy	01/2005
	Corporate Complaint Policy	05/2005
	Corporate Appeal Policy	10/2005
	Member Communication – HMO Insolvency Policy	01/2005
	New Member Orientation Policy	01/2005
	Member Termination Policy	02/2005
ER 3	Written Materials in Alternative Formats Policy	02/2005
ER 4	Privacy Policy	2005
	Member Requests for Medical Records Policy	2005
ER 5	Emergent and Urgent Care Services Policy	04/28/2005
ER 6	Advance Directives Policy	01/2005
ER 7	Notice of Privacy Practices	2005
QA 1.1	The 2005 Availability Report	2005
	Anthem Availability Monitoring of Practitioners, Providers and Practice Sites Policy and Procedure	03/2005
	Managed Care Accessibility Analysis for Hospitals	01/30/06
	Medicaid Primary Care Physician Agreement	
QA 1.2	Anthem Credentialing and Recredentialing Program Description	07/2005
QA 2.1	Access to Care Policy	12/15/2005
	Member Handbook and Evidence of Coverage Book	07/2005
QA 3.1	Access to Care Policy	12/15/2005
QA 4.1	Out of Network Authorizations for Specialty Care	03/15/2005
	Continuation of Care Policy	03/15/2005
QA 5	Availability Monitoring of Practitioners, Provider and Practice Sites Policy	03/2005
	Cultural Needs and Preferences Report	2005
	Written Materials in Alternative Formats Policy	02/2005
QA 6.1	Care Management Policy	12/15/2005
	Anthem Continuity and Coordination of Care Monitoring Policy and Procedure	03/2005
QA 7-8	Advanced Care Management Desktop Procedure Children with Special Health Care Needs	03/03/2005
QA 9.1	Care Management Policy	12/15/2005
QA 10.1	Care Management Policy	12/15/2005
	Transition of Care Policy	03/15/2005
QA 10.2	Care Management Policy	12/15/2005
	Continuity and Coordination between Medical Care and Behavioral Health Care 2004-2005	2004-2005
	Anthem Continuity and Coordination of Care Monitoring Policy and Procedure	03/2005
QA 10.3	Wellpoint, Inc. Privacy Policy Manual Version 5.0	2004
QA 11-14	Anthem Blue Cross and Blue Shield Utilization Management Program Description2005	05/02/2005
	Utilization Management Program	2005
	Access to Care Policy	12/05
	Staff Inter-Rater Reliability	8/2005
	Physician Inter-Rater Reliability Policy	8/2005
	Review Process-Medical Necessity and/or/ Experimental/Investigative Policy	3/15/2005
	Anthem Delegated Activities Policy	3/2005

Summary of Documents Reviewed		
Element	**Document**	**Date**
	Associate, Consultant, or Agent Compensation-UR Conduct Policy	8/2005
	Medical Review Decision Making and Timeliness of Decisions Policy	3/15/2005
QA 15.1	Anthem Credentialing and Recredentialing Program Description	07/2005
QA 15.2	Anthem Credentialing and Recredentialing Program Description	07/2005
QA 15.3	Anthem Credentialing and Recredentialing Program Description	07/2005
QA 16.1	Anthem Credentialing and Recredentialing Program Description	07/2005
QA 17.1	Anthem Credentialing and Recredentialing Program Description	07/2005
QA 18.1	Anthem Credentialing and Recredentialing Program Description	07/2005
QA 19.0	Anthem Member Handbook and Evidence of Coverage	07/2005
QA 20.1	Member Handbook and Evidence of Coverage	07/2005
QA 20.2	Member Notification of Practitioner Termination Policy and Procedure	05/2005
QA 21	Anthem Member Appeal Policy	10/2005
	Anthem member Complaint Policy	5/2005
	Anthem Member Handbook and Evidence of Coverage	7/2005
	Medical Review Decision Making and Timeliness of Decisions Policy	3/15/2005
QA 22.1	Anthem Delegated Activities Policy and Procedure	03/2005
QA 22.2	Sample Delegated Credentialing / Recredentialing Agreement contract	Undated
QA 22.3	Delegated Activities Agreement	Undated
QA 22.4	2004 QI Program evaluation	2005
QA 23.1	Anthem Clinical Practice Guideline Development and Monitoring Policy	03/2005
	Anthem Clinical Practice Guideline Development and Monitoring Policy and Procedure	03/15/2005
	2005 Managed Care Advisory Panel Minutes	03/22/2005 and 07/26/2005
QA 24.1	Anthem Clinical Practice Guideline Development and Monitoring Policy and Procedure	03/2005
QA 25.1	Criteria: Application, Review, Evaluation, and Disclosure Policy	03/15/2005
QA 26.1	Anthem Health Plans of Virginia, Inc. Quality Improvement Program 2005	2005
QA 26.2	Activity: Improving the Use of Appropriate Medications for People with Asthma,	2005
QA 27.1	Anthem Over/Under Utilization Monitoring Policy and Procedure	undated
QA 28.1	Advanced Care Management Desktop Procedure Children with Special Health Care Needs	03/03/2005
QA 29.1	Application Disaster Recovery Plan - TriMed Application Profile	undated
QA 29.2	Medicaid Enrollment Process	undated
	Utilization Management Data and System Security Process	02/17/04
QA 29.3	Medicaid Enrollment Process	undated
	Anthem Member Complaint Policy and Procedure	05/2005
	Anthem Professional Provider Billing Guidelines	01/01/2005
QA 29.4	Anthem Professional Provider Billing Guidelines	01/01/2005
QA 29.5	Wellpoint, Inc. Privacy Policy Manual Version 5.0	2004
GS 1-11	Anthem Member Appeal	10/2005
	Anthem Member Complaint	05/2005
	Access to Care	12/2005
	Care Management	12/15/2005
	Anthem Blue Cross and Blue Shield Utilization Management Program Description2005	05/02/2005
	Staff Inter-Rater Reliability	08/2005
	Physician Inter-Rater Reliability	08/2005
	Review Process - Medical Necessity and/or Experimental/Investigative	03/15/2005
	Anthem Delegated Activities	03/2005

Summary of Documents Reviewed		
Element	**Document**	**Date**
	Medical Review Decision Making & Timeliness of Decisions	03/15/2005
	Associate, Consultant, or Agent Compensation—Utilization Review Conduct	08/2005
	Anthem Member Appeal	10/2005
	Anthem Member Complaint	05/2005

Section II - Performance Improvement Projects

Introduction

As part of the annual External Quality Review (EQR), Delmarva conducted a review of Performance Improvement Projects (PIPs) submitted by each managed care organization (MCO) contracting with the Department of Medical Assistance Services (DMAS). According to its contract with DMAS, each MCO is required to conduct PIPs that are designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction. According to the contract, the PIPs must include the measurement of performance using objective quality indicators, the implementation of system interventions to achieve improvement in quality, evaluation of the effectiveness of the interventions, and planning and initiation of activities for increasing or sustaining improvement.

The guidelines utilized for PIP review activities were CMS' *Validation of PIPs* protocols. CMS' *Validation of PIPs* assists EQROs in evaluating whether or not the PIP was designed, conducted, and reported in a sound manner and the degree of confidence a state agency could have in the reported results.

For the current review period, calendar year (CY) 2005, the PIP validation protocols and tools established in 2003 were used. Reviewers evaluated each project submitted using the CMS validation tools. This included assessing each project across ten steps. These ten steps include:
Step 1: Review the Selected Study Topics,
Step 2: Review the Study Questions,
Step 3: Review the Selected Study Indicator(s),
Step 4: Review the Identified Study Population,
Step 5: Review Sampling Methods,
Step 6: Review the MCO's Data Collection Procedures,
Step 7: Assess the MCO's Improvement Strategies,
Step 8: Review Data Analysis and Interpretation of Study Results,
Step 9: Assess the Likelihood that Reported Improvement is Real Improvement, and
Step 10: Assess Whether the MCO has Sustained its Documented Improvement.

As Delmarva staff conducted the review, each component within a standard (step) was rated as "yes," "no," or "N/A" (not applicable). Components were then rolled up to create a determination of "met", "partially met", "unmet" or "not applicable" for each of the ten standards. Table 1 describes this scoring methodology.

Table 1. Rating Scale for Performance Improvement Project Validation Review

Rating	Rating Methodology
Met	All required components were present.
Partially Met	One but not all components were present.
Unmet	None of the required components were present.
Not Applicable	None of the required components are applicable.

Results

This section presents an overview of the findings of the Validation Review conducted for each PIP submitted by the MCO. Each MCO's PIP was reviewed against all 27 components contained within the ten standards.

The results of the ten activities assessed for each PIP submitted by Anthem Blue Cross/Blue Shield are presented in Table 2 below.

Table 2. 2005 Performance Improvement Project Review for Anthem Blue Cross/Blue Shield

Activity Number	Activity Description	Review Determination	
		Adolescent Immunization Combination 2 Rate	Improving the Use of Appropriate Medications for People with Asthma
1	Assess the Study Methodology	Met	Met
2	Review the Study Question(s)	Met	Met
3	Review the Selected Study Indicator(s)	Met	Met
4	Review the Identified Study Population	Met	Met
5	Review Sampling Methods	Met	Not Applicable
6	Review Data Collection Procedures	Partially Met	Partially Met
7	Assess Improvement Strategies	Met	Met
8	Review Data Analysis and Interpretation of Study Results	Met	Met
9	Assess Whether Improvement is Real Improvement	Met	Met
10	Assess Sustained Improvement	Met	Not Applicable

Conclusions and Recommendations

Conclusions

Anthem Blue Cross/Blue Shield provided two PIPs for review. These included, (1) Adolescent Immunization Combination 2 Rate and (2) Improving the Use of Appropriate Medications for People with Asthma. These were evaluated using the Validating Performance Improvement Projects protocol, commissioned by the Department of Health and Human Services, CMS, which allows assessment among 10 different project activities.

For the Adolescent Immunization Project, the MCO received a review determination of "Met" for nine (9) elements, "Partially Met" for one (1) element, and "Unmet" for zero (0) elements.

For the second project, Improving the Use of Appropriate Medications for People with Asthma, Anthem Blue Cross/Blue Shield received a review determination of "Met" for seven (7) elements, "Partially Met" for one (1) element, and a review determination of "Unmet" for zero (0) elements. Activity 5, Sampling Methods, was "Not Applicable" as the entire population was used by the MCO for each measurement.

Activity 10, Sustained Improvement, was also "Not Applicable" because the HEDIS results for the 2005 measurement year had not been calculated when the PIP was submitted.

Recommendations

Based on a review of each of the two PIPs provided by the MCO, the following recommendations are made to improve the PIP process and performance.

- Qualifications of staff used to collect data for both PIPs should be specified.

QUALITY IMPROVEMENT PROJECT
VALIDATION WORKSHEET

ID of evaluator: JJ

Date of evaluation: 3/23/2006

Demographic Information
MCO/PHP Name or ID: Project Leader Name:
Telephone Number:
Name of Quality Improvement Project: Anthem – Adolescent Immunizations
Dates in Study Period: to: Phase:

Step 1. REVIEW THE SELECTED STUDY TOPIC(S)			
Component/Standard	**Y, N, or N/A**	**Comment**	**Cites and Similar References**
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	Y	Approximately 71% of Anthem's population are children. The MCO described health risks to adolescents on a national level and included an opportunity to improve, given their HEDIS adolescent immunization rates were below the 25th percentile.	QAPI RE2Q1 QAPI RE2Q2,3,4 QIA S1A1 MMCD 2004
1.2 Did the MCO s/PHPs QIPs, over time, address a broad spectrum of key aspects of enrollee care and services?	Y	The MCO seeks to improve adolescent immunization rates.	QAPI RE2Q1QI A S1A2 MMCD 2004
1.3 Did the MCOs/PHPs QIPs over time, include all enrolled populations; i.e. , did not exclude certain enrollees such as with those with special health care needs?	Y	Anthem included all eligible members in the study.	QAPI RE2Q1 QIA S1A2 MMCD 2004
Assessment Component: **Met**			
Met – All required components are present. Partially Met – Some, but not all components are present. Unmet -None of the required components are present. N/A -None of these components apply.			
Recommendations:			

Step 2. REVIEW THE STUDY QUESTION(S)			
Component/Standard	**Y, N, or N/A**	**Comment**	**Cites and Similar References**
2.1 Was there a clear problem statement that described the rationale for the study?	Y	The plan identified an opportunity to improve their adolescent immunization rate based on their HEDIS data.	QIA S1A3 MMCD 2004
Assessment Component: **Met**			
Met – All required components are present. Partially Met – Some, but not all components are present. Unmet -None of the required components are present. N/A -None of these components apply.			
Recommendations:			

Step 3. REVIEW SELECTED STUDY INDICATOR(S)			
Component/Standard	**Y, N, or N/A**	**Comment**	**Cites and Similar References**
3.1 Did the study use objective, clearly defined, measurable indicators?	Y	The MCO's indicator was established according to HEDIS methodology and is clearly defined and measurable.	QAPI RE3Q1 QAPI RE3Q2-6 QAPI RE3Q7-8 QIA S1B2 QIA S1B3
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes?	Y	An Increase in adolescent immunization rates has been identified as a valid proxy measure for improved health status.	QAPI RE3Q9 QIA S1B1
Assessment Component: **Met**			
Met – All required components are present. Partially Met – Some, but not all components are present. Unmet -None of the required components are present. N/A -None of these components apply.			
Recommendations:			

Step 4. REVIEW THE IDENTIFIED STUDY POPULATION			
Component/Standard	**Y, N, or N/A**	**Comment**	**Cites and Similar References**
4.1 Did the MCO/PHP clearly define all Medicaid enrollees to whom the study question(s) and indicator(s) are relevant?	Y	The MCO specified the population to which the study applies.	QAPI RE2Q1 QAPI RE3Q2-6
4.2 If the MCO/PHP studied the entire population, did its data collection approach capture all enrollees to whom the study question applied?	Y	The MCO utilized HEDIS data collection methodology, which includes all eligible members in the study.	QAPI RE4Q1&2 QAPI RE5Q1.2 QIA I B, C MMCD 2004
Assessment Component: **Met**			
Met – All required components are present. Partially Met – Some, but not all components are present. Unmet -None of the required components are present. N/A -None of these components apply.			
Recommendations:			

Step 5. REVIEW SAMPLING METHODS			
Component/Standard	**Y, N, or N/A**	**Comment**	**Cites and Similar References**
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable?	Y	HEDIS specifications and methodology meet the requirements for this component.	QAPI RE5Q1.3a QIA S1C2
5.2 Did the MCO/PHP employ valid sampling techniques that protected against bias?	Y	HEDIS specifications and methodology meet the requirements for this component.	QAPI RE5Q1.3b-c QIA S1C2
Specify the type of sampling or census used:			
5.3 Did the sample contain a sufficient number of enrollees?	Y	HEDIS specifications and methodology meet the requirements for this component.	QAPI RE5Q1.3b-c QIA S1C2
Assessment Component: **Met**			
Met – All required components are present. Partially Met – Some, but not all components are present. Unmet -None of the required components are present. N/A -None of these components apply.			
Recommendations:			

Step 6. REVIEW DATA COLLECTION PROCEDURES			
Component/Standard	**Y, N, or N/A**	**Comment**	**Cites and Similar References**
6.1 Did the study design clearly specify the data to be collected?	**Y**	The MCO's study design clearly specified the data to be collected.	QAPI RE4Q1&2
6.2 Did the study design clearly specify the sources of data?	**Y**	The data collection methodology included medical record abstraction and programmed pulls from claims/encounter data.	QAPI RE4Q1&2
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicator(s) apply?	**Y**	The MCO utilized HEDIS methodology in its study design; therefore, valid and reliable data was collected that represents the population being studied.	QAPI RE4Q3a QAPI RE4Q3b QIA S1C1 QIA S1C3
6.4 Did the data collection methodology provide for a consistent, accurate data collection over the time periods studied?	**Y**	The MCO collected data according to HEDIS specifications which provided for consistent, accurate data collection over the time periods studied.	QAPI RE4Q1&2 QAPI RE4Q3b QAPI RE7Q1&2
6.5 For baseline measurement does the study design prospectively specify a data analysis plan for the remeasurement years?	**N/A**	N/A for remeasurement years.	QAPI RE5Q1.2
Assessment Component: **Partially Met**			
Met – All required components are present. Partially Met – Some, but not all components are present. Unmet -None of the required components are present. N/A -None of these components apply.			
Recommendations: Describe qualifications of staff collecting data.			

Step 7. ASSESS IMPROVEMENT STRATEGIES			
Component/Standard	**Y, N, or N/A**	**Comment**	**Cites and Similar References**
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?	**Y**	The MCO continues to target interventions toward the parents of adolescent age children.	QAPI RE6Q1a QAPI RE6Q1b QAPI RE1SQ1-3 QIA S3.5 QIA S4.1 – S4.3 MMCD 02-04 MMCD 99-02 MMCD 99-07
Assessment Component: **Met**			
Met – All required components are present. Partially Met – Some, but not all components are present. Unmet -None of the required components are present. N/A -None of these components apply.			
Recommendations:			

Step 8: REVIEW DATA ANALYSIS AND INTERPRETATION OF STUDY RESULTS			
Component/Standard	**Y, N, or N/A**	**Comment**	**Cites and Similar References**
8.1 Did the MCO/PHP present numerical PIP results accurately and clearly and analyze initial and repeat measurements?	Y	The MCO presented numerical QIP results and findings accurately and clearly.	
8.2 Did the analysis performed include an interpretation of the extent to which the PIP was successful and identify quantitative and qualitative factors that influenced the results of the initial and repeat measurements?	Y	The analysis identified initial and repeat measurements, including statistical significance. No factors were identified that threaten internal and external validity.	QAPI RE7Q2 QIA S1C4 QIA S2.1 MMCD 2004
8.3 Did the MCO/PHP identify follow-up activities and/or interventions based on their analysis of the findings?	Y	The analysis of the study data did include an interpretation of the extent to which its QIP was successful.	QIA S2.2
Assessment Component: **Met**			
Met – All required components are present. Partially Met – Some, but not all components are present. Unmet -None of the required components are present. N/A -None of these components apply.			
Recommendations:			

Step 9. ASSESS WHETHER IMPROVEMENT IS REAL IMPROVEMENT			
Component/Standard	**Y, N, or N/A**	**Comment**	**Cites and Similar References**
9.1 Was the same methodology as the baseline measurement used when measurement was repeated?	Y	The MCO used the same methodology as the baseline measurement.	QAPI RE7Q2 QAPI 2SQ1-2 QIA S1C4 QIA S2.2 QIA S3.1, S3.3, S3.4 MMCD 2004
9.2 Was there quantitative improvement in processes or outcomes of care in any of the indicators measured by the MCO/PHP?	Y	Anthem was able to demonstrate improvement in the adolescent immunization rate.	QAPI RE7Q3 QIA S2.3
9.3 Does the reported improvement in performance have face validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention?	Y	The improvement documented in the indicator measured was due to the interventions implemented by the MCO.	QIA S3.2 MMCD 2004
9.4 Is there any statistical evidence that any observed performance improvement is true improvement?	Y	The MCO included a statistically significant increase in the quantitative analysis.	QIA S2.3
Assessment Component: **Met**			
Met – All required components are present. Partially Met – Some, but not all components are present. Unmet -None of the required components are present. N/A -None of these components apply.			
Recommendations:			

Step 10. ASSESS SUSTAINED IMPROVEMENT			
Component/Standard	**Y, N, or N/A**	**Comment**	**Cites and Similar References**
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods?	**Y**	The MCO demonstrated sustained improvement over time in the adolescent immunization measure.	QAPI RE2SQ3 QIA II, III MMCD 2004
Assessment Component: **Met**			
Met – All required components are present. Partially Met – Some, but not all components are present. Unmet -None of the required components are present. N/A -None of these components apply.			
Recommendations:			

Key Findings
1. Strengths: The plan utilized a HEDIS measure and HEDIS methodology.
2. Best Practices:
3. Issues identified by MCO (Barrier Analysis): The MCO continues to identify that parents of adolescent age children are not aware of the importance and benefits of immunizations.
4. Action taken by MCO (Barrier Analysis): The MCO continues to target the parents of the adolescent age children by publishing articles in the member newsletters and by mailing parents and requesting copies of immunization records. Incentives were utilized to encourage participation.
5. Recommendations for the next submission: • Describe qualifications of staff collecting data.

QUALITY IMPROVEMENT PROJECT
VALIDATION WORKSHEET

ID of evaluator: DMP

Date of evaluation: 2/27/2006

Demographic Information
MCO/PHP Name or ID: Project Leader Name:
Telephone Number:
Name of Quality Improvement Project: Anthem – Asthma
Dates in Study Period: to: Phase:

Step 1. REVIEW THE SELECTED STUDY TOPIC(S)			
Component/Standard	**Y, N, or N/A**	**Comment**	**Cites and Similar References**
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	Y	Anthem selected the study topic based upon review of Medicaid HMO plan specific and national data. Asthma ranks in the top 10 diagnoses for inpatient admissions, emergency department visits, and outpatient office visits.	QAPI RE2Q1 QAPI RE2Q2,3,4 QIA S1A1 MMCD 2004
1.2 Did the MCO s/PHPs QIPs, over time, address a broad spectrum of key aspects of enrollee care and services?	Y	This PIP, over time, addresses multiple care and delivery systems which would improve enrollee outcomes.	QAPI RE2Q1QI A S1A2 MMCD 2004
1.3 Did the MCOs/PHPs QIPs over time, include all enrolled populations; i.e. , did not exclude certain enrollees such as with those with special health care needs?	Y	HEDIS specifications were followed to determine the eligible population.	QAPI RE2Q1 QIA S1A2 MMCD 2004
Assessment Component: **Met**			
Met – All required components are present. Partially Met – Some, but not all components are present. Unmet -None of the required components are present. N/A -None of these components apply.			
Recommendations:			

Step 2. REVIEW THE STUDY QUESTION(S)			
Component/Standard	**Y, N, or N/A**	**Comment**	**Cites and Similar References**
2.1 Was there a clear problem statement that described the rationale for the study?	Y	Anthem has evaluated their plan specific and national data which provided their rational for the study. Asthma ranks in their top 10 diagnoses for inpatient admissions, emergency department visits and outpatient visits.	QIA S1A3 MMCD 2004
Assessment Component: **Met**			
Met – All required components are present. Partially Met – Some, but not all components are present. Unmet -None of the required components are present. N/A -None of these components apply.			
Recommendations:			

Step 3. REVIEW SELECTED STUDY INDICATOR(S)			
Component/Standard	**Y, N, or N/A**	**Comment**	**Cites and Similar References**
3.1 Did the study use objective, clearly defined, measurable indicators?	Y	HEDIS specifications were used for the indicator.	QAPI RE3Q1 QAPI RE3Q2-6 QAPI RE3Q7-8 QIA S1B2 QIA S1B3
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes?	Y	The use of appropriate asthma medications have been demonstrated to improve long-term control for individuals with asthma and serves as a proxy measure for changes in health status.	QAPI RE3Q9 QIA S1B1
Assessment Component: **Met**			
Met – All required components are present. Partially Met – Some, but not all components are present. Unmet -None of the required components are present. N/A -None of these components apply.			
Recommendations:			

Step 4. REVIEW THE IDENTIFIED STUDY POPULATION			
Component/Standard	**Y, N, or N/A**	**Comment**	**Cites and Similar References**
4.1 Did the MCO/PHP clearly define all Medicaid enrollees to whom the study question(s) and indicator(s) are relevant?	Y	HEDIS methodology was used to define the Medicaid enrollees to whom the study question and indicator applies.	QAPI RE2Q1 QAPI RE3Q2-6
4.2 If the MCO/PHP studied the entire population, did its data collection approach capture all enrollees to whom the study question applied?	Y	HEDIS methodology and specifications were used to capture all eligible enrollees.	QAPI RE4Q1&2 QAPI RE5Q1.2 QIA I B, C MMCD 2004
Assessment Component: **Met**			
Met – All required components are present. Partially Met – Some, but not all components are present. Unmet -None of the required components are present. N/A -None of these components apply.			
Recommendations:			

Step 5. REVIEW SAMPLING METHODS			
Component/Standard	**Y, N, or N/A**	**Comment**	**Cites and Similar References**
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable?	N/A	No sampling was used for this PIP. Anthem included the entire eligible population.	QAPI RE5Q1.3a QIA S1C2
5.2 Did the MCO/PHP employ valid sampling techniques that protected against bias?	N/A	No sampling was used for this PIP. Anthem included the entire eligible population.	QAPI RE5Q1.3b-c QIA S1C2
Specify the type of sampling or census used:	N/A		
5.3 Did the sample contain a sufficient number of enrollees?	N/A	No sampling was used for this PIP. Anthem included the entire eligible population.	QAPI RE5Q1.3b-c QIA S1C2
Assessment Component: N/A			
Met – All required components are present. Partially Met – Some, but not all components are present. Unmet -None of the required components are present. N/A -None of these components apply.			
Recommendations: This area of assessment was not applicable as Anthem did not use sampling for this PIP. Anthem included the entire eligible population.			

Step 6. REVIEW DATA COLLECTION PROCEDURES			
Component/Standard	**Y, N, or N/A**	**Comment**	**Cites and Similar References**
6.1 Did the study design clearly specify the data to be collected?	Y	HEDIS specifications were used which clearly specified the data that was to be collected.	QAPI RE4Q1&2
6.2 Did the study design clearly specify the sources of data?	Y	HEDIS specifications were used to include collection of administrative and pharmacy data.	QAPI RE4Q1&2
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicator(s) apply?	Y	HEDIS methodology was used to collect valid and reliable data.	QAPI RE4Q3a QAPI RE4Q3b QIA S1C1 QIA S1C3
6.4 Did the data collection methodology provide for a consistent, accurate data collection over the time periods studied?	Y	HEDIS specifications were used each year which provided for consistent and accurate data collection.	QAPI RE4Q1&2 QAPI RE4Q3b QAPI RE7Q1&2
6.5 For baseline measurement does the study design prospectively specify a data analysis plan for the remeasurement years?	N/A	Anthem has not completed an analysis of the data during this submission due to the timelines of submission. It is expected that once their data is provided, an analysis will be provided.	QAPI RE5Q1.2
Assessment Component: **Partially Met**			
Met – All required components are present. Partially Met – Some, but not all components are present. Unmet -None of the required components are present. N/A -None of these components apply.			
Recommendations: Include qualifications of staff/personnel used to collect the data.			

Step 7. ASSESS IMPROVEMENT STRATEGIES			
Component/Standard	**Y, N, or N/A**	**Comment**	**Cites and Similar References**
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?	**Y**	Another barrier analysis was completed after MY 2004 with the same barriers identified. Anthem continued their Asthma Disease Management program, articles in member newsletter and phone outreach in MY 2005 which can be expected to increase their rates.	QAPI RE6Q1a QAPI RE6Q1b QAPI RE1SQ1-3 QIA S3.5 QIA S4.1 – S4.3 MMCD 02-04 MMCD 99-02 MMCD 99-07
Assessment Component: **Met**			
Met – All required components are present. Partially Met – Some, but not all components are present. Unmet -None of the required components are present. N/A -None of these components apply.			
Recommendations:			

Step 8: REVIEW DATA ANALYSIS AND INTERPRETATION OF STUDY RESULTS			
Component/Standard	**Y, N, or N/A**	**Comment**	**Cites and Similar References**
8.1 Did the MCO/PHP present numerical PIP results accurately and clearly and analyze initial and repeat measurements?	Y	Anthem presents numberical QIP results clearly and accurately inluding both numerators and denominators. It is expected that MY 2005 results will be presented in the same manner.	
8.2 Did the analysis performed include an interpretation of the extent to which the PIP was successful and identify quantitative and qualitative factors that influenced the results of the initial and repeat measurements?	Y	The analysis has always included initial and repreat measurements and statistical significance. It is expected that MY 2005 results will be presented in the same way.	QAPI RE7Q2 QIA S1C4 QIA S2.1 MMCD 2004
8.3 Did the MCO/PHP identify follow-up activities and/or interventions based on their analysis of the findings?	Y	It is expected that Anthem will complete an analysis to include interpretation of the extent to which the PIP was successful along with follow-up activities once the results are in.	QIA S2.2
Assessment Component: **Met**			
Met – All required components are present. Partially Met – Some, but not all components are present. Unmet -None of the required components are present. N/A -None of these components apply.			
Recommendations:			

Step 9. ASSESS WHETHER IMPROVEMENT IS REAL IMPROVEMENT			
Component/Standard	**Y, N, or N/A**	**Comment**	**Cites and Similar References**
9.1 Was the same methodology as the baseline measurement used when measurement was repeated?	**Y**	No substantive changes were made to the HEDIS specifications from HEDIS 2001 to 2005. It is expected that this will be the same for HEDIS 2006.	QAPI RE7Q2 QAPI 2SQ1-2 QIA S1C4 QIA S2.2 QIA S3.1, S3.3, S3.4 MMCD 2004
9.2 Was there quantitative improvement in processes or outcomes of care in any of the indicators measured by the MCO/PHP?	**N/A**	Documented quantitative improvement is unable to be determined at this time. Once the remeasurement results are calculated for MY 2005, Anthem will present this information.	QAPI RE7Q3 QIA S2.3
9.3 Does the reported improvement in performance have face validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention?	**N/A**	Improvement in performance is unable to be determined at this time. Once the remeasurement results are calculated for MY 2005, Anthem will present this information.	QIA S3.2 MMCD 2004
9.4 Is there any statistical evidence that any observed performance improvement is true improvement?	**N/A**	Once the remeasurement results are calculated for MY 2005, Anthem will present this information as they have for the past measurement years.	QIA S2.3
Assessment Component: **Met**			
Met – All required components are present. Partially Met – Some, but not all components are present. Unmet -None of the required components are present. N/A -None of these components apply.			
Recommendations:			

Step 10. ASSESS SUSTAINED IMPROVEMENT			
Component/Standard	**Y, N, or N/A**	**Comment**	**Cites and Similar References**
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods?	**N/A**	Sustained improvement is unable to be determined until the MY 2005 results are calculated.	QAPI RE2SQ3 QIA II, III MMCD 2004
Assessment Component: **N/A**			
Met – All required components are present. Partially Met – Some, but not all components are present. Unmet -None of the required components are present. N/A -None of these components apply.			
Recommendations:			

Key Findings
1. Strengths: HEDIS specifications and methodologies were used in this study.
2. Best Practices:
3. Issues identified by MCO (Barrier Analysis): Lack of knowledge of self/caregiver-management of asthma, lack of knowledge and ability to identify individual asthma triggers, and lack of asthma self-management/caregiver action plans that include long term control of asthma.
4. Action taken by MCO (Barrier Analysis): Asthma Disease Management Program, Member newsletter articles and telephone outreach,
5. Recommendations for the next submission: • Include qualifications of staff/personnel used to collect the data.

Activity Name: Improving Adolescent Immunizations

Section I: Activity Selection and Methodology

A. Rationale. Use objective information (data) to explain your rationale for why this activity is important to members or practitioners *and* why there is an opportunity for improvement.

Approx. 157,500 members as of January 2006

Approx. 112,000 as of January 2006 are children (71%)

Health Risks to Adolescents if Not Immunized

- Immunizations successfully and inexpensively reduce the incidence of dangerous and costly diseases.
- Of the estimated 125,000 new cases of hepatitis B each year, more than 70% affect adolescents and young adults.[1] Hepatitis B is highly infectious and can unknowingly be passed to others.
- If the measles vaccine was discontinued in the U.S., 3-4 million measles cases would occur annually and result in more than 1,800 deaths, 1,000 cases of encephalitis, and 80,000 cases of pneumonia.[2]
- Immunizations are one of the most cost effective health intervention strategies available, saving society more than $5 for each dollar spent.[3]

Problem Statement

The plan identified an opportunity to improve the adolescent immunization rate based on the analysis of HEDIS data. The following factors were considered:

- 2002 HEDIS data demonstrated that adolescent immunizations were below the 25th percentile. This rate offers an opportunity to analyze, evaluate and develop intervention(s) to improve the rate.

B. Quantifiable Measures. List and define *all* quantifiable measures used in this activity. Include a goal or benchmark for each measure. If a goal was established, list it. If you list a benchmark, state the source. Add sections for additional quantifiable measures as needed.

Quantifiable Measure #1:	HEDIS Adolescent Immunizations

[1] Cassels AM, Patterson SM, Tobin JP. Improving Adolescent and Adult Immunization Rates in Community Practice. Clinical Directors Network, Inc. Adolescent/Adult Immunization Quality Improvement Project. 2000.

[2] Abramson JS, Pickering LK. US Immunization Policy. JAMA 2002; 287(4):505-509

[3] Ibid.

Numerator:	For members in the denominator, those who had a second dose of MMR, and three hepatitis B by their 13th birthday.
Denominator:	Medicaid adolescents who turn 13 years of age during the measurement year and have been continuously enrolled for 12 months prior to their 13th birthday. No more than 1-month gap in coverage during the 12 months prior to the 13th birthday.
First measurement period dates:	1/1/01-12/31/01
Baseline Benchmark:	37.3
Source of benchmark:	National Averages according to NCQA State of Health Care Quality
Baseline goal:	37.3 NCQA State of Health Care Quality

C. Baseline Methodology.
• **HEDIS Methodology was used for the measure Adolescent Immunizations.**

C.1 Data Sources.

[ ] Medical/treatment records
[ ] Administrative data:
[ ] Claims/encounter data [ ] Complaints [ ] Appeals [ ] Telephone service data [ ] Appointment/access data
[X] Hybrid (medical/treatment records and administrative)
[ ] Pharmacy data
[ ] Survey data (attach the survey tool and the complete survey protocol)
[ ] Other (list and describe):

_____

_____

C.2 Data Collection Methodology. Check all that apply and enter the measure number from Section B next to the appropriate methodology.

If medical/treatment records, check below:
[X] Medical/treatment record abstraction

If survey, check all that apply:
[ ] Personal interview
[ ] Mail
[ ] Phone with CATI script
[ ] Phone with IVR
[ ] Internet
[ ] Incentive provided
[ ] Other (list and describe):

_____

_____

If administrative, check all that apply:
[ ] Programmed pull from claims/encounter files of all eligible members
[X] Programmed pull from claims/encounter files of a sample of members
[ ] Complaint/appeal data by reason codes
[ ] Pharmacy data
[ ] Delegated entity data
[ ] Vendor file
[ ] Automated response time file from call center
[ ] Appointment/access data
[ ] Other (list and describe):

_____

_____

C.3 Sampling. If sampling was used, provide the following information. Sampling Methodology was HEDIS methodology.

Measure	Sample Size	Population	Method for Determining Size *(describe)*	Sampling Method *(describe)*

C.4 Data Collection Cycle.	Data Analysis Cycle.
[X] Once a year [ ] Twice a year [ ] Once a season [ ] Once a quarter [ ] Once a month [ ] Once a week [ ] Once a day [ ] Continuous [ ] Other (list and describe): _____ _____	[X] Once a year [ ] Once a season [ ] Once a quarter [ ] Once a month [ ] Continuous [ ] Other (list and describe): _____ _____

C.5 Other Pertinent Methodological Features. Complete only if needed.

- N/A

D. Changes to Baseline Methodology. Describe any changes in methodology from measurement to measurement.

- There were no substantive changes made to the HEDIS specifications from 2002 to 2005.

Section II: Data / Results Table

Complete for each quantifiable measure; add additional sections as needed.

#1 Quantifiable Measure: Adolescent Immunizations

Time Period Measurement Covers	Measurement	Numerator	Denominator	Rate or Results	Comparison Benchmark*	Comparison Goal**	Statistical Test and Significance*
HEDIS 2002 1/1/01-12/31/01	*Baseline:*	98	411	23.84	37.3	32	
HEDIS 2003 1/1/02-12/31/02	Remeasurement 1	155	426	36.38	43.1	45	Baseline to Remeasurement 1 p=0.000
HEDIS 2004 1/1/03-12/31/03	Remeasurement 2	205	411	49.88	51.9	52	Baseline to Remeasuremnt 2 p=0.000
HEDIS 2005 1/1/04-12/31/04	Remeasurement 3	236	431	54.76	57.3	57	Baseline to Remeasurment 3 p=0.000

If used, specify the test, p value, and specific measurements (e.g., baseline to remeasurement #1, remeasurement #1 to remeasurement #2, etc., or baseline to final remeasurement) included in the calculations. NCQA does not require statistical testing.

*Source: NCQA's "The State of Health Care Quality" Report for Years 2004 and 2005. The comparison benchmarks are Medicaid National Averages for this measure.

**Internal goal

Section III: Analysis Cycle

Complete this section for EACH analysis cycle presented.

A. Time Period and Measures That Analysis Covers.

Analysis Cycle I – HEDIS 2002 (MY 2001)

- Adolescent Immunizations

Analysis Cycle II – HEDIS 2003 (MY 2002) [Baseline – Remeasurement 1]

- Adolescent Immunizations

Analysis Cycle III - HEDIS 2004 (MY 2003) [Baseline - Remeasurement 2]

- Adolescent Immunizations

Analysis Cycle IV - HEDIS 2005 (MY 2004) [Baseline - Remeasurement 3]

- Adolescent Immunizations

B. Analysis and Identification of Opportunities for Improvement. Describe the analysis and include the points listed below.

ANALYSIS CYCLE I: Calendar Year 2001 [Baseline]

QUANTITATIVE ANALYSIS

Measure # 1: ADOLESCENT IMMUNIZATIONS

- Comparison with the goal/benchmark:
  - The HEDIS 2002 (MY 2001) rate was 23.84; 8.16 percentage points below the goal, and 13.46 percentage points below the National Average.
- Reasons for changes to goals:
  - Not changed.
- Comparison with previous measurement:
  - 2001 is the baseline analysis cycle.
- Trends, increases or decreases in performance or changes in statistical significance (if used):
  - 2001 is the baseline analysis cycle.

QUALITATIVE ANALYSIS

In attempt to improve the adolescent immunization rate, the Clinical Improvement Team (this multi-disciplinary team is comprised of a Medical Director who is a pediatrician, Quality Improvement Director, and QI Clinical Specialist) conducted a barrier analysis (consisting of brainstorming and literature review) and use of Managed Care Advisory Panel -external physician consultant representing the major state academies and chapters in Virginia. Barrier analysis suggests that parents with adolescent age children are not aware of the importance and benefits of immunizations. Review of literature suggests that repeated reminders and education about the importance of immunization in young adults will impact the rates.

- Barrier: Lack of parental knowledge about immunizations needed beyond preschool and early childhood years.
- Opportunity: Educate parents about the importance of immunizations beyond the preschool and early childhood years.
- Intervention:
  - Send immunization reminder postcards to parents of members turning 11 and 12 years old
  - Publish preventive care guidelines in member newsletter annually
  - Publish articles about medical attention needed for the adolescent population
  - Provide parent education with use of Healthtape library recording educating parents about preventive care and immunizations needed for children of

all ages.

- Barrier: Adolescent children are normally in good health and therefore, parents are not inclined to seek medical attention unless there is an illness.
- Opportunity: Remind parents of adolescent preventive health exams including up to date immunizations.
- Intervention:
  - Send immunization reminder postcards to parents of members turning 11 and 12 years old
  - Publish preventive care guidelines in member newsletter annually
  - Send letter in quarter prior to 13th birthday to parents informing them of the recommended immunizations and encouraging them to check their child's immunization status with their current primary care physician

- Barrier: Lack of provider knowledge regarding the Adolescent Immunization Rate measurement and program goals.
- Opportunity: Communicate the Adolescent Immunization HEDIS® Rate to providers.
- Intervention:
  - Communication Quality Improvement Program to physicians in newsletter.
  - Provide physician incentive for adolescent well visits
  - Communicate Preventive Care Guidelines to practitioners in newsletter.

ANALYSIS CYCLE II: Calendar Year 2002 [Baseline – Remeasurement 1]

QUANTITATIVE ANALYSIS

Measure # 1: ADOLESCENT IMMUNIZATIONS

- Comparison with the goal/benchmark:
  - The HEDIS 2003 (MY 2002) rate was 36.38; 8.62 percentage points below the goal, and 6.72 percentage points below the National Average.
- Reasons for changes to goals:
  - The goal was increased to 45% which was the National Average for Medicaid rates according to National Committee for Quality Assurance.
- Comparison with previous measurement:
  - The rate increased from 23.84% to 36.38%, a increase of 12.54 percentage points.
- Trends, increases or decreases in performance or changes in statistical significance (if used):

- The rate increased from the baseline rate to remeasurement 1 was statistically significant at the 95% confidence level, p= 0.000

QUALITATIVE ANALYSIS

In attempt to improve the adolescent immunization rate, the Clinical Improvement Team (this multi-disciplinary team is comprised of a Medical Director who is a pediatrician, Quality Improvement Director, and QI Clinical Specialist) conducted a barrier analysis (consisting of brainstorming and literature review) and use of Managed Care Advisory Panel -external physician consultant representing the major state academies and chapters in Virginia. Barrier analysis suggests that parents with adolescent age children are not aware of the importance and benefits of immunizations. Review of literature suggests that repeated reminders and education about the importance of immunization in young adults will impact the rates. No new barriers were identified during this analysis cycle. The previous barriers remain the focus of intervention.

The change process for preventive care measures such as immunizations occurs over time and through repeated reinforcement. We anticipate future improvements as members and practitioners continue to be aware of the importance of immunizations in adolescents.

ANALYSIS CYCLE III: Calendar Year 2003 [Baseline – Remeasurement 2]

QUANTITATIVE ANALYSIS

Measure # 1: ADOLESCENT IMMUNIZATIONS

- Comparison with the goal/benchmark:
  - The HEDIS 2004 (MY 2003) rate was 49.88; 2.12 percentage points below the goal, and 2.02 percentage points below the National Average.
- Reasons for changes to goals:
  - The goal was increased to 52% which was the National Average for Medicaid rates according to National Committee for Quality Assurance.
- Comparison with previous measurement:
  - The rate increased from 36.38% to 49.88%, a increase of 13.5 percentage points.
- Trends, increases or decreases in performance or changes in statistical significance (if used):
  - The rate increased from the baseline rate to remeasurement 2 was statistically significant at the 95% confidence level, p= 0.000.

QUALITATIVE ANALYSIS

In attempt to improve the adolescent immunization rate, the Clinical Improvement Team (this multi-disciplinary team is comprised of a Medical Director who is a pediatrician, Quality Improvement Director, and QI Clinical Specialist) conducted a barrier analysis (consisting of brainstorming and literature review) and use of Managed Care Advisory Panel -external physician consultant representing the major state academies and chapters in Virginia. Barrier analysis suggests that parents with adolescent age children are not aware of the importance and benefits of immunizations. Review of literature suggests that repeated reminders and education about the importance of immunization in young adults will impact the rates In addition, it was identified that adolescents receive care via the health department, school immunization programs and health fairs. Medical records located in the primary care physician's office do not necessarily reflect immunizations given in other locations. It was identified that the Virginia Department of Health database records immunizations given at school programs and health department locations in Virginia. These recommendations were presented for discussion with the following results:

- Barrier: Lack of parental knowledge about immunizations needed beyond preschool and early childhood years.
- Opportunity: Educate parents about the importance of immunizations beyond the preschool and early childhood years.
- Intervention:
    - Send immunization reminder postcards to parents of members turning 11 and 12 years old
    - Publish preventive care guidelines in member newsletter annually
    - Publish articles about medical attention needed for the adolescent population
    - Provide parent education with use of Healthtape library recording educating parents about preventive care and immunizations needed for children of all ages.
    - Send Televox phone reminders to parents as follow up to reminder post cards.
    - Perfect Prize Program- Perfect Teen- members enter a drawing for Wal-Mart gift card for sending in verification of appropriate immunizations by 13th birthday

- Barrier: Medical record at primary care physician's office is not complete..
- Opportunity: Educate parents about the importance of keeping the medical record and immunization record current in the primary care physician office.
- Intervention:
    - Revised letter sent to parents in the quarter prior to the 13th birthday; letter requests parents to send up to date immunization record to health plan, carabiner/radio is mailed to those who return a completed form.
    - Send member list to Virginia Department of Health to collect additional immunizations in their database.

The change process for preventive care measures such as immunizations occurs over time and through repeated reinforcement. We anticipate future improvements as members and practitioners continue to be aware of the importance of immunizations in adolescents.

ANALYSIS CYCLE IV: Calendar Year 2004 [Baseline – Remeasurement 3]

QUANTITATIVE ANALYSIS

Measure # 1: ADOLESCENT IMMUNIZATIONS

- Comparison with the goal/benchmark:
  - The HEDIS 200 (MY 2004) rate was 54.76; 2.24 percentage points below the goal, and 2.54 percentage points below the National Average.
- Reasons for changes to goals:
  - The goal was increased to 57% which was the National Average for Medicaid rates according to National Committee for Quality Assurance.
- Comparison with previous measurement:
  - The rate increased from 49.88% to 54.76%, a increase of 4.88 percentage points.
- Trends, increases or decreases in performance or changes in statistical significance (if used):
  - The rate increased from the baseline rate to remeasurement 3 was statistically significant at the 95% confidence level, p= 0.000

QUALITATIVE ANALYSIS

In attempt to improve the adolescent immunization rate, the Clinical Improvement Team (this multi-disciplinary team is comprised of a Medical Director who is a pediatrician, Quality Improvement Director, and QI Clinical Specialist) conducted a barrier analysis (consisting of brainstorming and literature review) and use of Managed Care Advisory Panel -external physician consultant representing the major state academies and chapters in Virginia. Barrier analysis suggests that parents with adolescent age children are not aware of the importance and benefits of immunizations. Review of literature suggests that repeated reminders and education about the importance of immunization in young adults will impact the rates The change process for preventive care measures such as immunizations occurs over time and through repeated reinforcement and previous barriers remain the focus for interventions The committee observes the current interventions over time are positively impacting the adolescent immunization rates.

Section IV: Interventions Table

Interventions Taken for Improvement as a Result of Analysis. List chronologically the interventions that have had the most impact on improving the measure. Describe only the interventions and provide quantitative details whenever possible (e.g., "hired 4 customer service reps" as opposed to "hired customer service reps"). Do not include intervention planning activities.

Date Implemented (MM / YY)	Check if Ongoing	Interventions	Barriers That Interventions Address
Jan - Dec 2002	X	Mailed postcard reminders about upcoming immunizations to parents of children as they turn 11 and 12 years old. Mailed monthly during the members birth month.	Lack of parental knowledge about immunizations needed beyond preschool and early childhood years.
Feb 2002	X	Mailed letters to parents the quarter prior to the child turning 13 years of age in order to capture immunizations given at school, health fairs or health departments. The letter included information about keeping the child's medical record current and requested they complete the form about immunizations given in places other than primary care physician office. The physician office is asked to file this documentation to update the members' immunization record and if the member's immunizations are not up to date encourage the parent to make an appointment for a visit.	Lack of parental knowledge about immunizations needed beyond preschool and early childhood years.
Mar 2002	X	Published Preventive Care Guidelines to practitioners via newsletter, *Professional Forum*.	Lack of practitioner knowledge regarding Adolescent Immunization rate measurement and goals.
Spring 2002	X	Published Preventive Care Guidelines to members via newsletter, *Winning Health.*	Lack of parental knowledge about immunizations needed beyond preschool and early childhood years.

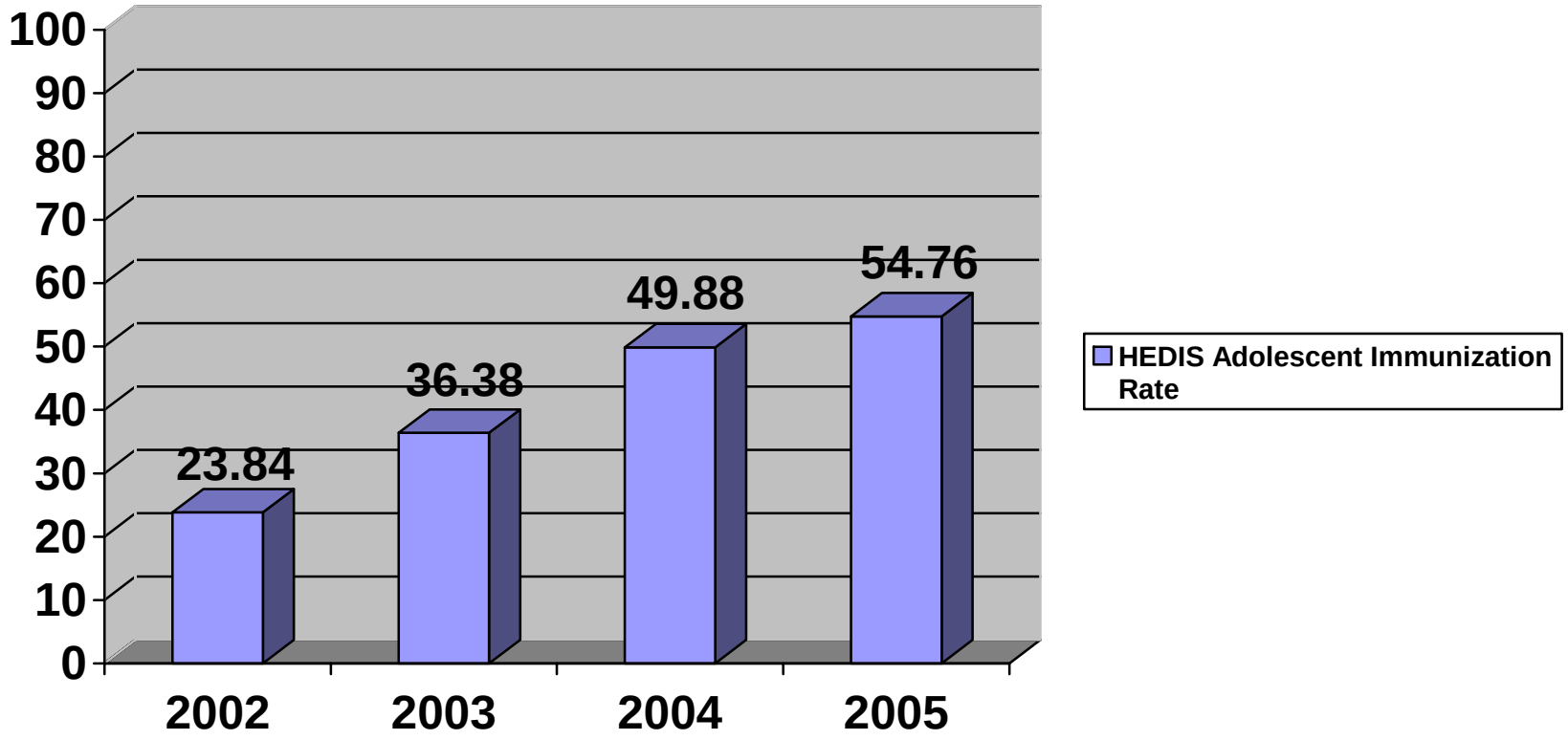
April 2002		Incentive payout mailed to practitioners participating in the Performance Extra Program for 2001 - one of the indicators in this program is Adolescent Well Visits which ultimately leads to increased compliance with immunization of this age group. The physician needed a score of 28% or better to receive the incentive for adolescent visits, 30% of the physicians met that goal and received payment. Of the physicians that were eligible for the incentive they cared for 60% of the members in this age group.	Lack of practitioner knowledge regarding Adolescent Immunization rate measurement and goals.
June 2002		Educated practitioners about Performance Extra Incentive for Physician program for 2003 announced and published in the provider newsletter. The criteria to meet the incentive for Adolescent Well visits outlined in this article.	Lack of practitioner knowledge regarding Adolescent Immunization rate measurement and goals.
Aug 2002		Random telephone survey completed to physicians with members that received a immunization letter and form to see if providers are getting completed forms returned.	Lack of practitioner knowledge regarding Adolescent Immunization rate measurement and goals.
Aug 2002		Informed providers of random telephone survey results via practitioner newsletter. The results indicated providers are receiving the completed immunization forms. Physicians were advised to review the form when returned and if the child has not completed the recommended adolescent immunizations or has not had a recent well check-up to contact the parent to make an appointment.	Lack of practitioner knowledge regarding Adolescent Immunization rate measurement and goals.
Fall 2002	X	Revised copy of letters mailed to parents of children who are approaching 13 years old. Requests parent to send a copy of immunization records from physician medical records. This information is entered into database in Quality Improvement Department.	Lack of parental knowledge about immunizations needed beyond preschool and early childhood years.
Jan 2003	X	Published Immunization Schedule for practitioners in practitioner newsletter *Professional Forum*	Lack of practitioner knowledge regarding Adolescent Immunization rate measurement and goals.

Spring 2003	X	Published Immunization Schedule for members in member newsletter *Winning Health*	Lack of parental knowledge about immunizations needed beyond preschool and early childhood years.
Oct 2003	X	Completed telephone calls via Televox, an automated phone system, to parents of children turning 13 informing them of the importance of adolescent immunizations. Calls to members occur quarterly.	Lack of parental knowledge about immunizations needed beyond preschool and early childhood years.
Nov 2003		Mailed Perfect Prize Program- Perfect Teen. Parents enter drawing for Wal-Mart gift certificate for sending a completed immunization record prior to teens 13th birthday.	Lack of parental knowledge about immunizations needed beyond preschool and early childhood years.
Jan 2004	X	Published Immunization Schedule for practitioners in practitioner newsletter *Professional Forum*	Lack of practitioner knowledge regarding Adolescent Immunization rate measurement and goals.
Spring 2004	X	Published Immunization Schedule for members in member newsletter *Winning Health*	Lack of parental knowledge about immunizations needed beyond preschool and early childhood years.
Summer 2004		Published article about qQality Improvement Program which includes information about the importance of immunizations in member newsletter *Winning Health*	Lack of parental knowledge about immunizations needed beyond preschool and early childhood years.
Winter 2005		Published article " Why Kids Need Check Ups" for members in member newsletter *Winning Health*	Lack of parental knowledge about immunizations needed beyond preschool and early childhood years.
Jan 2005	X	Published Immunization Schedule for practitioners in practitioner newsletter *Professional Forum*	Lack of practitioner knowledge regarding Adolescent Immunization rate measurement and goals.
Spring 2005	X	Published Immunization Schedule for members in member newsletter *Winning Health*	Lack of parental knowledge about immunizations needed beyond preschool and early childhood years.
Summer 2005		Published article "We Care About Your Health" for members in member newsletter *Winning Health* article focuses on information about quality program and the importance of preventive care.	Lack of parental knowledge about immunizations needed beyond preschool and early childhood years.
Fall 2005	X	Letters mailed to parents of children who are approaching 13 years old requesting a copy of the immunization record. Carabiner/radio reward added for returning this information to the health plan.	Lack of parental knowledge about immunizations needed beyond preschool and early childhood years.

Section V: Chart or Graph (Optional)

Attach a chart or graph for any activity having more than two measurement periods that shows the relationship between the timing of the intervention (cause) and the result of the remeasurements (effect). Present one graph for each measure unless the measures are closely correlated, such as average speed of answer and call abandonment rate. Control charts are not required, but are helpful in demonstrating the stability of the measure over time or after the implementation.

MEASURE #1: HEDIS
Adolescent Immunization Rate



NCQA Quality Improvement Activity Form

Activity Name: Improving the Use of Appropriate Medications for People with Asthma

Section I: Activity Selection and Methodology

A. Rationale. Use objective information (data) to explain your rationale for why this activity is important to members or practitioners *and* why there is an opportunity for improvement.

Increase the rate of use of appropriate medications for long term control of asthma for People with Asthma.

- Asthma ranks in the top 10 diagnoses for Inpatient admissions and Emergency Department (ED) visits and Outpatient Office Visits for the years 2003 and 2004. In 2003, 19.8 million people, or 8 percent of all Americans, had a diagnosis of active asthma.[1] In 2002, asthma accounted for 1.2 million hospital outpatient visits, 1.9 million emergency department visits, 12.7 million doctors visits, 484,000 hospitalizations and 4,261 deaths.[2] Asthma is the leading cause of school absenteeism attributed to chronic conditions.
- The Plan has an Asthma Management Program that promotes the use of appropriate medications for long term control and provides asthma education and child and caregiver support by expert RN Consultants. These elements have been shown to improve outcomes for people with asthma.

B. Quantifiable Measure(s). List and define *all* quantifiable measures used in this activity. Include a goal or benchmark for each measure. If a goal was established, list it. If you list a benchmark, state the source. Add sections for additional quantifiable measures as needed.

Quantifiable Measure #1:	Appropriate asthma medication, combined rate for ages 5-9 years, 10-17 years and 18-56 years
Numerator:	For each member in the denominator, those who had at least one dispensed prescription for inhaled corticosteroids, nedocromil, cromolyn sodium, leukotriene modifiers, or methylxanthines in the measurement year (MY).
Denominator:	All Medicaid HMO members aged 5 –56 years by 12/31 of the measurement year who were continuously enrolled during the measurement year and the year preceding the measurement with no more than one gap in enrollment of up to 45 days during each year of enrollment . Members were identified as having persistent asthma by having ANY of the following in the year prior to the measurement year: 1) at least four asthma medication dispensing events OR 2) at least one Emergency Department (ED) visit with asthma (ICD-9 code 493) as the principal diagnosis OR at least one hospitalization with asthma(ICD-9 code 493) as the principal diagnosis OR 4) at least four outpatient asthma visits with asthma (ICD-9 code 493) as one of the listed diagnoses AND at least two asthma medication dispensing events.

[1] Centers for Disease Control and Prevention. Asthma: national health Interview Study Data. 2003. http://www.cdc.gov/asthma/NHIS/default.htm.

[2] Centers for Disease Control and Prevention. Asthma Prevalence, Health Care Use and Mortality, 2002. CDC National Center for Health Statistics 2002. http://www.cdc.gov/NCHS/products/pubs/pubd/hestats/ashtma/asthma.htm.

First measurement period dates:	01/01/2000 – 12/31/2000
Baseline Benchmark:	New measure in HEDIS 2001
Source of benchmark:	
Baseline goal:	65%

C.1 HEDIS/CAHPS® 2.0H Methodology. (*Note:* HEDIS/CAHPS® methodology is not required.)

Was HEDIS/CAHPS® methodology used? Complete for each measure**.**

[√] Yes.

List the years used: 2001 , 2003; 2004, 2005

* 2002 data incorrect and unable to recover

List the HEDIS® measure and/or CAHPS® 2.0H question numbers used and/or the composite questions used:

Use of Appropriate Medications for People with Asthma

[ ] No.

C.2 Data Sources.

[ ] Medical/treatment records
[**X**] Administrative data:
[**X**] Claims/encounter data [ ] Complaints [ ] Appeals [ ] Telephone service data [ ] Appointment/access data
[ ] Hybrid (medical/treatment records and administrative)
[**X**] Pharmacy data
[ ] Survey data (attach the survey tool and the complete survey protocol)
[ ] Other (list and describe):

_____

_____

If HEDIS/CAHPS®methodology was used for all measures, *skip to Section 1.D.* Complete Sections 1.C.3–6 only for each measure that does not use HEDIS/CAHPS® methodology.

C.3 Data Collection Methodology. Check all that apply and enter the measure number from Section B next to the appropriate methodology.

If medical/treatment records, check below:

[ ] Medical/treatment record abstraction

If survey, check all that apply:

[ ] Personal interview
[ ] Mail
[ ] Phone with CATI script
[ ] Phone with IVR
[ ] Internet
[ ] Incentive provided
[ ] Other (list and describe):

_____

_____

If administrative, check all that apply:

[**X**] Programmed pull from claims/encounter files of all eligible members
[ ] Programmed pull from claims/encounter files of a sample of members
[ ] Complaint/appeal data by reason codes
[ ] Pharmacy data
[ ] Delegated entity data
[ ] Vendor file
[ ] Automated response time file from call center
[ ] Appointment/access data
[ ] Other (list and describe):

_____

_____

C.4 Sampling. If sampling was used, provide the following information.

Measure	Population Size	Sample Size	Method for Determining Size *(describe)*	Sampling Method *(describe)*
No sampling	100%			

C.5 Data Collection Cycle.	Data Analysis Cycle.
[**X**] Once a year [ ] Twice a year [ ] Once a season [ ] Once a quarter [ ] Once a month [ ] Once a week [ ] Once a day [ ] Continuous [ ] Other (list and describe): _____ _____	[**X**] Once a year [ ] Once a season [ ] Once a quarter [ ] Once a month [ ] Continuous [ ] Other (list and describe): _____ _____

C.6 Other Pertinent Methodological Features. Complete only if needed.

D. Changes to Baseline Methodology. Describe any changes in methodology from measurement to measurement.

- For the baseline measurement HEDIS 2001 (MY2000) the rate was calculated separately for Anthem's two HMO Medicaid entities (Peninsula Health Care, Inc. and Priority Health Care, Inc.)
- In 2001, Anthem received permission to combine the two HMO entity rates for HEDIS 2001 for analysis purposes. Since the Asthma Medication measure is administrative only, the combined rate was calculated as a simple rate using all eligible members in the denominator and all numerator positives in the numerator.
- Also in 2001, Anthem added an additional Medicaid HMO in the central region, HealthKeepers, Inc., making a total of three Medicaid HMO's.
- For HEDIS 2003 (MY2002) NCQA allowed Anthem to calculate and submit one combined rate for all of its Medicaid HMOs.
- No substantive changes were made to the HEDIS specifications from HEDIS 2001 to 2005. The NDC lists were updated annually so that there were additions and deletions to the drug lists used to calculate the rates.

Section II: Data / Results Table

Complete for each quantifiable measure; add additional sections as needed.

#1 Quantifiable Measure: Use of Appropriate Medications for Asthma – Ages 5 – 56 years HMO Medicaid

Time Period Measurement Covers	Measurement	Numerator	Denominator	Rate or Results	Comparison Benchmark	Comparison Goal	Statistical Test and Significance*
1/1/2000 – 12/31/2000 (HEDIS 2001)	*Baseline:*	345	578	59.7 50th Percentile	68.33 90th Percentile	65.0	Baseline to Remeasurement 1 p=0.041 Baseline to Remeasurement 2 p=.0000 Baseline to Remeasurement 3 p=0000
1/1/2002 – 12/31/2002 (HEDIS 2003)	Remeasurement 1:	462	852	54.23 75th Percentile	70.89 90th Percentile	68.0	
1/1/2003 – 12/31/2003 (HEDIS 2004)	Remeasurement 2:	903	1310	68.93 75th Percentile	70.89 90th Percentile	70	
1/1/2004 - 12/21/2004 (HEDIS 2005)	Remeasurement 3	801	1169	68.52	73.1 90th Percentile	73	

If used, specify the test, p value, and specific measurements (e.g., baseline to remeasurement #1, remeasurement #1 to remeasurement #2, etc., or baseline to final remeasurement) included in the calculations. NCQA does not require statistical testing.

Section III: Analysis Cycle
Complete this section for EACH analysis cycle presented.

A. Time Period and Measures That the Analysis Covers.

Analysis Cycle I – HEDIS 2001 (MY 2000)
- Use of Appropriate Medications for Asthma – Ages 5-56 years

Analysis Cycle II– HEDIS 2003 (MY 2002) (Baseline-Remeasurement 1)
- Use of Appropriate Medications for Asthma – Ages 5-56 years

Analysis Cycle III – HEDIS 2004 (MY 2003) (Remeasurement 1-Remeasurement 2)
- Use of Appropriate Medications for Asthma – Ages 5-56 years

Analysis Cycle IV – HEDIS 2005 (MY 2004) (Remeasurement 2-Remeasurement 3)
- Use of Appropriate Medications for Asthma – Ages 5-56 years

B. Identifying and Analyzing Opportunities for Improvement. Describe the analysis and include the points listed below.

ANALYSIS CYCLE I: Calendar Year 2000 (Baseline)

QUANTITATIVE ANALYSIS

MEASURE #1: APPROPRIATE ASTHMA MEDICATION

- **Comparison with the goal/benchmark:**
  - The HEDIS 2001 (MY 2000) rate was 5.3 percentage points below the goal, and 8.63 percentage points below the 90th percentile.
- **Reasons for changes to goals:**
  - Not changed.
- **Comparison with previous measurement**
  - 2000 is the baseline analysis cycle.
- **Trends, increases or decreases in performance or changes in statistical significance (if used):**
  - 2000 is the baseline analysis cycle.

QUALITATIVE ANALYSIS

The Managed Care Advisory Panel (MCAP), consisting of Family Practice Physicians and Specialists analyzed the Appropriate Use of Asthma Medications rates in an effort to identify factors impacting the rates. The MCAP made recommendations for improving the asthma medication rates. These recommendations were reported to the Quality Improvement Committee (QIC), made up of Vice Presidents and Directors who reviewed the recommendations and made implementation strategy decisions. The main technique used is brainstorming based on the expertise and experience of the Committee members.

- **Barrier:** Lack of knowledge self/caregiver management of asthma.
- **Opportunity:** Increase knowledge and self/caregiver-management skills of members with asthma.
- **Intervention:** Asthma Disease Management Program (1st Quarter 1999 – Ongoing).

- **Barrier:** Lack of asthma self/caregiver-management action plans that include long term control of asthma.
- **Opportunity:** Increase use of action plans for long term control of asthma.
- **Intervention:** Asthma Disease Management Program (1st Quarter 1999 – Ongoing).

- **Barrier:** Lack of knowledge and ability to identify individual asthma triggers.
- **Opportunity:** Increase knowledge and ability of self/caregiver to identify asthma triggers.
- **Intervention:** Asthma Disease Management Program (1st Quarter 1999 – Ongoing).

- **Barrier:** Practice variation among physician in treating asthma for long term control
- **Opportunity:** Decrease variation among physicians in treatment for long term control of asthma.
- **Intervention:** Developed and distributed evidence-based Asthma Clinical Practice Guidelines to physicians (1998 – Ongoing , every 2 years).

- **Barrier:** Member/caregivers and physicians not aware of the availability of the Asthma Disease Management Program.
- **Opportunity:** Increase awareness and participation in the Asthma Disease Management Program.
- **Intervention:** Information about the Asthma Disease Management Program and how to access it were mailed to targeted members and physicians (1999 – Ongoing).

ANALYSIS CYCLE II: Calendar Year 2002

QUANTITATIVE ANALYSIS

MEASURE #1: APPROPRIATE ASTHMA MEDICATION

- **Comparison with the goal/benchmark:**
  - The HEDIS 2003 (MY 2002) rate was approximately 13.77 percentage points below the goal, and 16.6 percentage points below the 90th percentile.

- **Reasons for changes to goals:**
  - The MCAP Committee increased the goal to 68% striving for the Quality Compass 90th percentile.

- **Comparison with previous measurement**
  - The rate decreased by 5.47%.

- **Trends, increases or decreases in performance or changes in statistical significance (if used):**
  - The Plan rate decreased from baseline to remeasurement 1, and was statistically significant at the 95% Confidence Level , p=0.041.

QUALITATIVE ANALYSIS

The Managed Care Advisory Panel (MCAP), consisting of Family Practice Physicians and Specialists analyzed the Appropriate Use of Asthma Medications rates in an effort to identify factors impacting the rates. The MCAP made recommendations for improving the asthma medication rates. These recommendations were reported to the Quality Improvement Committee (QIC), made up of Vice Presidents and Directors who reviewed the recommendations and made implementation strategy decisions. The main technique is brainstorming based on the expertise and experience of the Committee members. No new barriers were identified during this analysis cycle. The previous barriers remain the focus of intervention. (see page 7 for previous barriers)

The asthma disease management program was implemented in February 1999. The initial program year did not yet significantly impact the rates. However, the change process for chronic disease management occurs over time, and through repeated reinforcement. We anticipate future improvements as the program impacts an increasing number of members and practitioners.

ANALYSIS CYCLE III: Calendar Year 2003

QUANTITATIVE ANALYSIS

MEASURE #1: APPROPRIATE ASTHMA MEDICATION

- **Comparison with the goal/benchmark:**
  - The HEDIS 2004 (MY 2003) rate was 1.07 percentage points below the goal, and 1.96 percentage points below the 90th percentile.

- **Reasons for changes to goals:**
  - The MCAP Committee increased the goal to 70% striving for the Quality Compass 90th percentile.

- **Comparison with previous measurement**
  - The rate increased by 14.7 percentage points from the previous year, and increased 9.23 percentage points from the baseline measurement.

- **Trends, increases or decreases in performance or changes in statistical significance (if used):**
  - The Plan rate increased from remeasurement 1 to remeasurement 2, and increased from baseline measurement which is statistically significant at the 95% Confidence Level., p=0.000.

QUALITATIVE ANALYSIS

The Managed Care Advisory Panel (MCAP), consisting of Family Practice Physicians and Specialists analyzed the statistically significant decrease in the Appropriate Use of Asthma Medications rates in an effort to identify factors impacting the rates. The MCAP made recommendations for improving the asthma medication rates. These recommendations were reported to the Quality Improvement Committee (QIC), made up of Vice Presidents and Directors who reviewed the recommendations and made implementation strategy decisions. The main technique is brainstorming based on the expertise and experience of the Committee members. The same barriers were identified during this analysis cycle. The committee discussed doing further analysis of members that are in the denominator due to emergency room visit or hospitalization. The committee also discussed ER physician's management of acute asthma attacks but the need to stress member follow-up with PCP to obtain appropriate medication management. There was a recommendation made to review the contact process for members in the disease management program. The previous barriers remain the focus of intervention. The committee observed that the disease management program interventions were positively impacting the care over time.

ANALYSIS CYCLE IV: Calendar Year 2004

QUANTITATIVE ANALYSIS

MEASURE #1: APPROPRIATE ASTHMA MEDICATION

- **Comparison with the goal/benchmark:**
  - The HEDIS 2005 (MY 2004) rate was 4.48 percentage points below the goal, and 4.58 percentage points below the 90th percentile.
- **Reasons for changes to goals:**
  - The MCAP Committee approved the goal of 73% in Fall 2005 striving for the Quality Compass 90th percentile.
- **Comparison with previous measurement**
  - The rate decreased by .41 percentage points from the previous years measurement and increased 8.82 percentage points from the baseline measurement.
- **Trends, increases or decreases in performance or changes in statistical significance (if used):**
  - The Plan rate increased from baseline to remeasurement 3 by 6.38 percentage points, a statistically significant increase at the 95% Confidence Level p=0.0000.

QUALITATIVE ANALYSIS

The Managed Care Advisory Panel (MCAP), consisting of Family Practice Physicians and Specialists analyzed the Appropriate Use of Asthma Medications rates in an effort to identify factors impacting the rates. The MCAP made recommendations for improving the asthma medication rates. These recommendations were reported to the Quality Improvement Committee (QIC), made up of Vice Presidents and Directors who reviewed the recommendations and made implementation strategy decisions. The main technique is brainstorming based on the expertise and experience of the Committee members. The same barriers were identified during this analysis cycle. There was a recommendation made to review the contact process for members in the disease management program and to forward a member list to HMC for those members that had asthma diagnosis and care received in calendar year 2004. The previous barriers remain the focus of intervention. The committee observed that the disease management program interventions were positively impacting the care over time.

Section IV: Interventions Table

Interventions Taken for Improvement as a Result of Analysis. List chronologically the interventions that have had the most impact on improving the measure. Describe only the interventions and provide quantitative details whenever possible (e.g., "hired 4 customer service reps" as opposed to "hired customer service reps"). Do not include intervention planning activities.

Date Implemented (MM / YY)	Check if Ongoing	Interventions	Barriers That Interventions Address
11/98	Yes Every 2 years	Published Pediatric Asthma Care Guidelines based on NIH NHLBI Guidelines to physicians in *Professional Forum*.	Practice variation among physicians in treating asthma for long term control
02/99	Yes	Implemented Asthma Disease Management Program by Health Management Corporation, a subsidiary of Anthem Blue Cross and Blue Shield. Members with asthma are identified with models using multiple claims events, demographic, clinical and pharmaceutical variables. Members are stratified into two groups: high intensity and low intensity based on use of services. HMC sends all members regardless of intensity outreach mailings and educational materials. High intensity members are targeted for telephonic case management, but any member, regardless of intensity may enroll in the program. HMC encouraged the active participation of minors identified as having asthma. Children between the ages of 2 years and 17 years are managed following standards for pediatric cases. Children are encouraged to take an active part in managing their health condition by their inclusion in the telephonic counseling sessions, with parental consent. Members also have access to the program through physician referral or through self-referral.	Lack of knowledge of self/caregiver-management of asthma Lack of asthma self-management/caregiver action plans that include long term control of asthma Lack of knowledge and ability to identify individual asthma triggers

	Yes	The Asthma Disease Management program has the following elements. • Policy: Management of Pediatric & Adult Participants • 24-Hour Nurse Line to help members/caregivers seeking information about asthma and advice on how to handle health care situations. • RN Consultants , provide clinical assessment and health education for adults & children with asthma. • Calls to individual members/caregivers to introduce the asthma care management program and enroll the member. • At enrollment, the nurse collects demographic information, medical history, current medications and immunizations and self-monitoring knowledge and results. The member is asked about activities and life style in order to provide information and support for changes if needed. • The nurse along with the participant prepares an Asthma Emergency Action Plan that helps to identify an imminent asthma attack, to monitor response to treatment, and to know when to call the doctor or go to the Emergency Department. • Program nurses plan and implement follow-up monitoring and counseling. Pediatric Asthma Alert Criteria and Key Intervention Quick References (KIQRs) are used to guide telephonic assessment and counseling. • Clinical Summary Reports are sent to the member's physician.	
Spring 1999		Published "Asthma Actions" in *Patient Care* newsletter to participating PCPs and Specialists. The newsletter also contains information about how to access the Asthma Disease Management Program.	Practice variation among physicians in treating asthma for long term control Members/Caregivers and physicians not aware of the availability of the Asthma Management Program

Summer 1999	Yes	Published "Controlling Your Asthma: Put Your Finger on the Trigger" in *Family Health –Asthma Care* newsletter to all members The newsletter provides the 1-800 number for a registered nurse 24/7 and a listing of print and web-based resources as standard content.	Lack of knowledge of self/caregiver-management of asthma Lack of knowledge and ability to identify individual asthma triggers Lack of asthma self-management/caregiver action plans that include long term control of asthma Members/Caregivers and physicians not aware of the availability of the Asthma Management Program
Summer 1999		Published review of recent research on "Reduction of beta Agonist Dose in Asthma" in *Family Health – Patient Care* newsletter to participating PCPs and Specialists. The newsletter also contains information about how to access the Asthma Disease Management Program	Practice variation among physicians in treating asthma for long term control Members/Caregivers and physicians not aware of the availability of the Asthma Management Program
Fall 1999	Yes	Published "Understanding Your Asthma Medications in *Family Health – Asthma Care* newsletter to all members identified as having asthma. The newsletter provides the 1-800 number for a registered nurse 24/7 and a listing of print and web-based resources as standard content.	Lack of knowledge of self/caregiver-management of asthma Lack of knowledge and ability to identify individual asthma triggers Lack of asthma self-management/caregiver action plans that include long term control of asthma Members/Caregivers and physicians not aware of the availability of the Asthma Management Program
Fall 1999		Published "Asthma in the Clinic" and web clinical research information sources in *Patient Care* newsletter to participating PCPs and Specialists. The newsletter also contains information about how to access the Asthma Disease Management Program.	Practice variation among physicians in treating asthma for long term control Members/Caregivers and physicians not aware of the availability of the Asthma Management Program
Fall 1999		Published "Take Special Care-Advice for Pregnant Women with Asthma" in *Winning Health* newsletter to members. The newsletter also contains information about how to enroll in the Asthma Disease Management Program.	Lack of knowledge of self/caregiver-management of asthma Lack of knowledge and ability to identify individual asthma triggers Lack of asthma self-management/caregiver action plans that include long term control of asthma Members/Caregivers and physicians not aware of the availability of the Asthma Management Program
11/00	Yes Every 2 years	Published updated Pediatric Asthma Care Guidelines based on the NIHNHLBI Guidelines to physicians in *Professional Forum*	Practice variation among physicians in treating asthma for long term control

Winter 1999		Published "Depression: What You Need to Know", an article about the link between asthma and depression in *Family Health – Asthma Care* to all members enrolled in the Asthma Disease Management Program. The newsletter provides the 1-800 number for a registered nurse 24/7 and a listing of print and web-based resources as standard content.	Lack of knowledge of self/caregiver-management of asthma Lack of knowledge and ability to identify individual asthma triggers Lack of asthma self-management/caregiver action plans that include long term control of asthma Members/Caregivers and physicians not aware of the availability of the Asthma Management Program
Winter 1999		Published "Asthma Undertreated in Elderly in *Patient Care* newsletter to participating PCPs and Specialists. The newsletter also contains information about how to access the Asthma Disease Management Program.	Practice variation among physicians in treating asthma for long term control Members/Caregivers and physicians not aware of the availability of the Asthma Management Program
Winter 1999		Published "Cockroaches-make asthma worse" in member newsletter.	Lack of knowledge and ability to identify individual asthma triggers
Spring 2000		Published "Peak Flow Zones: Know Your Safety Limits " in *Family Health – Asthma Care* to all members enrolled in the Asthma Disease Management Program. The newsletter provides the 1-800 number for a registered nurse 24/7 and a listing of print and web-based resources as standard content.	Lack of knowledge of self/caregiver-management of asthma Lack of knowledge and ability to identify individual asthma triggers Lack of asthma self-management/caregiver action plans that include long term control of asthma Members/Caregivers and physicians not aware of the availability of the Asthma Management Program
Summer 2000		Published "Asthma Care" in *Winning Health* member newsletter. The newsletter also contains information about how to access the Asthma Disease Management Program.	Lack of knowledge of self/caregiver-management of asthma Lack of knowledge and ability to identify individual asthma triggers Lack of asthma self-management/caregiver action plans that include long term control of asthma Members/Caregivers and physicians not aware of the availability of the Asthma Management Program

Fall 2000		Published "Breathe Easier With Anti-Inflammatory Medication " in *Family Health – Asthma Care* to all members enrolled in the Asthma Disease Management Program. The newsletter provides the 1-800 number for a registered nurse 24/7 and a listing of print and web-based resources as standard content.	Lack of knowledge of self/caregiver-management of asthma Lack of knowledge and ability to identify individual asthma triggers Lack of asthma self-management/caregiver action plans that include long term control of asthma Members/Caregivers and physicians not aware of the availability of the Asthma Management Program
Winter 2000		Published "Depression and Asthma " in *Family Health – Asthma Care* to all members enrolled in the Asthma Disease Management Program. The newsletter provides the 1-800 number for a registered nurse 24/7 and a listing of print and web-based resources as standard content.	Lack of knowledge of self/caregiver-management of asthma Lack of knowledge and ability to identify individual asthma triggers Lack of asthma self-management/caregiver action plans that include long term control of asthma Members/Caregivers and physicians not aware of the availability of the Asthma Management Program
Winter 2000		Published "Environmental Controls to Prevent Asthma Attacks" in *Patient Care* newsletter to participating PCPs and Specialists.	Practice variation among physicians in treating asthma for long term control Members/Caregivers and physicians not aware of the availability of the Asthma Management Program
11/02	Yes Every 2 years	Published updated Pediatric Asthma Care Guidelines based on the NIHNHLBI Guidelines to physicians in *Professional Forum*	Practice variation among physicians in treating asthma for long term control
Winter 2001		Published "Sidelining Stress", an article focused on the link between asthma and stress in *Family Health – Asthma Care* to all members enrolled in the Asthma Disease Management Program. The newsletter provides the 1-800 number for a registered nurse 24/7 and a listing of print and web-based resources as standard content.	Lack of knowledge of self/caregiver-management of asthma Lack of knowledge and ability to identify individual asthma triggers Lack of asthma self-management/caregiver action plans that include long term control of asthma Members/Caregivers and physicians not aware of the availability of the Asthma Management Program
Winter 2001		Published "Alcohol Can Make Asthma Worse" in *Winning Health* member newsletter.	Lack of knowledge and ability to identify individual asthma triggers

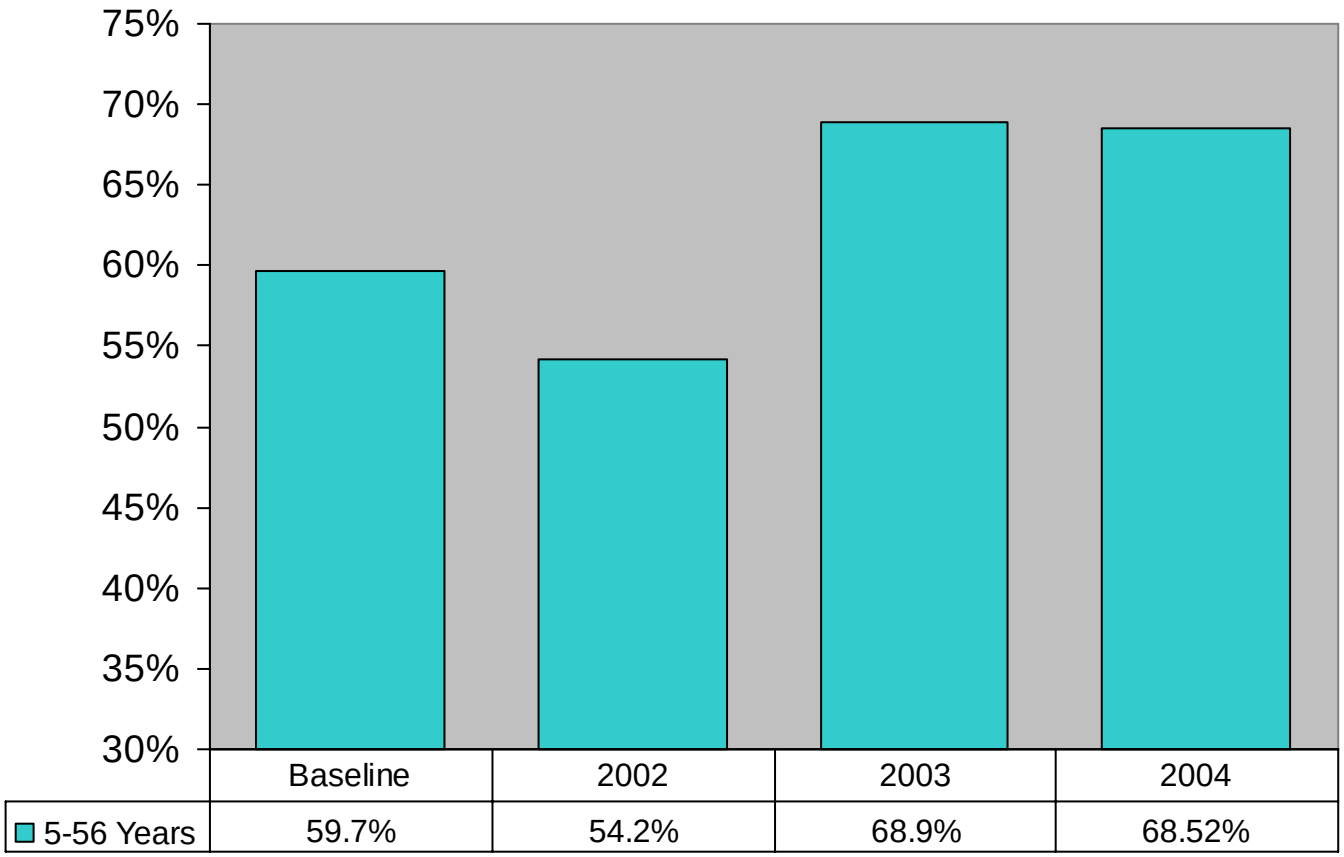
Spring 2002		Published “Breathing at Your Peak,” an article focused on using a peak flow meter to help control asthma in *Family Health – Asthma Care* to all members enrolled in the Asthma Disease Management Program. The newsletter provides the 1-800 number for a registered nurse 24/7 and a listing of print and web-based resources as standard content.	Lack of knowledge of self/caregiver-management of asthma Lack of knowledge and ability to identify individual asthma triggers Lack of asthma self-management/caregiver action plans that include long term control of asthma Members/Caregivers and physicians not aware of the availability of the Asthma Management Program
Summer 2002		Published "What's in the Air Can Make Asthma Worse" in Winning Health member newsletter. The newsletter also contains information about how to access the Asthma Disease Management Program.	Lack of knowledge of self/caregiver-management of asthma Lack of knowledge and ability to identify individual asthma triggers Lack of asthma self-management/caregiver action plans that include long term control of asthma Members/Caregivers and physicians not aware of the availability of the Asthma Management Program
Fall 2002		Training occurred at HMC with regards to working with Medicaid members. The following activities were completed: • Disease Management Nurse Consultants received Medicaid specific training • Monthly team meetings to discuss strategies to improve outcomes for this population • Contact protocols-increase number of attempted contacts prior to inactivating a case and attempting to reach member again 60 days after protocol has exhausted • Nurse consultants work closely with Medicaid Outreach Workers to increase contact and effectiveness in management of Medicaid members	Nurse consultants no aware of differences in managing Medicaid member population
Spring 2003		Published "Asthma-Exercise Can Be Good For You" in Winning Health member newsletter.	Lack of knowledge of self/caregiver-management of asthma

Summer 2003		Published "Stop Asthma Attacks Kick Smoke Out of the House" in Winning Health member newsletter.	Lack of knowledge of self/caregiver-management of asthma Lack of knowledge and ability to identify individual asthma triggers Lack of asthma self-management/caregiver action plans that include long term control of asthma
August 2003		Communicated 2004 Performance Extra Program- Indicators to include Appropriate Asthma Medications to physicians in Anthem Professional Forum.	Lack of physician knowledge regarding program and plan goals.
Fall 2003		Published "Exercise and Asthma-Help Your Child Stay in the game Using an Inhaler" in Winning Health member newsletter.	Lack of knowledge of self/caregiver-management of asthma Lack of knowledge and ability to identify individual asthma triggers Lack of asthma self-management/caregiver action plans that include long term control of asthma
Winter 2003/2004		Published "Controlling Asthma and Don't Lose Control of Asthma" in Winning Health member newsletter.	Lack of knowledge of self/caregiver-management of asthma Lack of knowledge and ability to identify individual asthma triggers Lack of asthma self-management/caregiver action plans that include long term control of asthma
Summer 2004		Published " When Asthma is an Emergency and Work with you Doctor to Control your Asthma" in Winning Health member newsletter.	Lack of knowledge of self/caregiver-management of asthma Lack of knowledge and ability to identify individual asthma triggers Lack of asthma self-management/caregiver action plans that include long term control of asthma
Fall 2004		Published "Control Mold to Breathe Easier and How to use a Peak Flow Meter" in Winning Health member newsletter.	Lack of knowledge of self/caregiver-management of asthma Lack of knowledge and ability to identify individual asthma triggers Lack of asthma self-management/caregiver action plans that include long term control of asthma

October 2004		Completed telephone calls via Televox ,an automated phone system, to members identified with the diagnosis of asthma that informs members about regular doctors visits, following doctors treatment plan, avoiding triggers and compliance with asthma medications.	Lack of knowledge of self/caregiver-management of asthma Lack of knowledge and ability to identify individual asthma triggers Lack of asthma self-management/caregiver action plans that include long term control of asthma
Fall 2005		Published "Help Spot Asthma Attacks, When Asthma is an Emergency and Take a Stand Against Smoking" in Winning Health member newsletter.	Lack of knowledge of self/caregiver-management of asthma Lack of knowledge and ability to identify individual asthma triggers Lack of asthma self-management/caregiver action plans that include long term control of asthma
Nov 2005		Completed telephone calls via Televox ,an automated phone system, to members identified with the diagnosis of asthma that informs members about regular doctors visits, following doctors treatment plan, avoiding triggers and compliance with asthma medications.	Lack of knowledge of self/caregiver-management of asthma Lack of knowledge and ability to identify individual asthma triggers Lack of asthma self-management/caregiver action plans that include long term control of asthma

Section V: Chart or Graph (Optional)

Attach a chart or graph for any activity having more than two measurement periods that shows the relationship between the timing of the intervention (cause) and the result of the remeasurements (effect). Present one graph for each measure unless the measures are closely correlated, such as average speed of answer and call abandonment rate. Control charts are not required, but are helpful in demonstrating the stability of the measure over time or after the implementation.



In 1999 Anthem implemented the Asthma Disease Management Program.